House Engrossed Senate Bill

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KEN BENNETT
SECRETARY OF STATE

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CHAPTER 232

SENATE BILL 1043

AN ACT

AMENDING SECTION 36-2903, ARIZONA REVISED STATUTES, AS AMENDED BY LAWS 2010, SEVENTH SPECIAL SESSION, CHAPTER 10, SECTION 1; AMENDING SECTION 36-2903.01, ARIZONA REVISED STATUTES, AS AMENDED BY LAWS 2010, SEVENTH SPECIAL SESSION, CHAPTER 10, SECTION 2; AMENDING SECTION 36-2905, ARIZONA REVISED STATUTES, AS AMENDED BY LAWS 2010, SEVENTH SPECIAL SESSION, CHAPTER 10, SECTION 3; AMENDING SECTION 36-2905.08, ARIZONA REVISED STATUTES, AS AMENDED BY LAWS 2010, SEVENTH SPECIAL SESSION, CHAPTER 10, SECTION 4; AMENDING SECTION 36-2907, ARIZONA REVISED STATUTES, AS AMENDED BY LAWS 2010, SEVENTH SPECIAL SESSION, CHAPTER 10, SECTION 5; AMENDING SECTION 36-2912, ARIZONA REVISED STATUTES, AS AMENDED BY LAWS 2010, SEVENTH SPECIAL SESSION, CHAPTER 10, SECTION 9; AMENDING TITLE 36, CHAPTER 29, ARIZONA REVISED STATUTES, BY ADDING ARTICLE 4; AMENDING SECTION 36-3408, ARIZONA REVISED STATUTES, AS AMENDED BY LAWS 2010, SEVENTH SPECIAL SESSION, CHAPTER 10, SECTION 11; AMENDING SECTION 38-651, ARIZONA REVISED STATUTES; AMENDING LAWS 2010, SEVENTH SPECIAL SESSION, CHAPTER 1, SECTION 133; REPEALING LAWS 2010, SEVENTH SPECIAL SESSION, CHAPTER 10, SECTION 10; MAKING APPROPRIATIONS; RELATING TO HEALTH CARE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 36-2903, Arizona Revised Statutes, as amended by Laws 2010, seventh special session, chapter 10, section 1, is amended to read:

36-2903. Arizona health care cost containment system; administrator; powers and duties of director and administrator; exemption from attorney general representation; definition

A. The Arizona health care cost containment system is established consisting of contracts with contractors for the provision of hospitalization and medical care coverage to members. Except as specifically required by federal law and by section 36-2909, the system is only responsible for providing care on or after the date that the person has been determined eligible for the system, and is only responsible for reimbursing the cost of care rendered on or after the date that the person was determined eligible for the system.

B. An agreement may be entered into with an independent contractor, subject to title 41, chapter 23, to serve as the statewide administrator of the system. The administrator has full operational responsibility, subject to supervision by the director, for the system, which may include any or all of the following:

1. Development of county-by-county implementation and operation plans for the system that include reasonable access to hospitalization and medical care services for members.

2. Contract administration and oversight of contractors, including certification instead of licensure for title XVIII and title XIX purposes.

3. Provision of technical assistance services to contractors and potential contractors.

4. Development of a complete system of accounts and controls for the system including provisions designed to ensure that covered health and medical services provided through the system are not used unnecessarily or unreasonably including but not limited to inpatient behavioral health services provided in a hospital. Periodically the administrator shall compare the scope, utilization rates, utilization control methods and unit prices of major health and medical services provided in this state in comparison with other states' health care services to identify any unnecessary or unreasonable utilization within the system. The administrator shall periodically assess the cost effectiveness and health implications of alternate approaches to the provision of covered health and medical services through the system in order to reduce unnecessary or unreasonable utilization.

5. Establishment of peer review and utilization review functions for all contractors.

6. Assistance in the formation of medical care consortiums to provide covered health and medical services under the system for a county.

7. Development and management of a contractor payment system.

8. Establishment and management of a comprehensive system for assuring the quality of care delivered by the system.

9. Establishment and management of a system to prevent fraud by members, subcontracted providers of care, contractors and noncontracting providers.

10. Coordination of benefits provided under this article to any member. The administrator may require that contractors and noncontracting providers are responsible for the coordination of benefits for services provided under this article. Requirements for coordination of benefits by noncontracting providers under this section are limited to coordination with standard health insurance and disability insurance policies and similar programs for health coverage.

11. Development of a health education and information program.

12. Development and management of an enrollment system.

13. Establishment and maintenance of a claims resolution procedure to ensure that ninety per cent of the clean claims shall be paid within thirty days of receipt and ninety-nine per cent of the remaining clean claims shall be paid within ninety days of receipt. For the purposes of this paragraph, "clean claims" has the same meaning prescribed in section 36-2904, subsection G.

14. Establishment of standards for the coordination of medical care and patient transfers pursuant to section 36-2909, subsection B.

15. Establishment of a system to implement medical child support requirements, as required by federal law. The administration may enter into an intergovernmental agreement with the department of economic security to implement this paragraph.

16. Establishment of an employee recognition fund.

17. Establishment of an eligibility process to determine whether a medicare low income subsidy is available to persons who want to apply for a subsidy as authorized by title XVIII.

C. If an agreement is not entered into with an independent contractor to serve as statewide administrator of the system pursuant to subsection B of this section, the director shall ensure that the operational responsibilities set forth in subsection B of this section are fulfilled by the administration and other contractors as necessary.

D. If the director determines that the administrator will fulfill some but not all of the responsibilities set forth in subsection B of this section, the director shall ensure that the remaining responsibilities are fulfilled by the administration and other contractors as necessary.

E. The administrator or any direct or indirect subsidiary of the administrator is not eligible to serve as a contractor.

F. Except for reinsurance obtained by contractors, the administrator shall coordinate benefits provided under this article to any eligible person who is covered by workers' compensation, disability insurance, a hospital and

medical service corporation, a health care services organization, an accountable health plan or any other health or medical or disability insurance plan including coverage made available to persons defined as eligible by section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e), or who receives payments for accident-related injuries, so that any costs for hospitalization and medical care paid by the system are recovered from any other available third party payors. The administrator may require that contractors and noncontracting providers are responsible for the coordination of benefits for services provided under this article. Requirements for coordination of benefits by noncontracting providers under this section are limited to coordination with standard health insurance and disability insurance policies and similar programs for health coverage. The system shall act as payor of last resort for persons eligible pursuant to section 36-2901, paragraph 6, subdivision (a), ~~or~~ section 36-2974 OR SECTION 36-2981, PARAGRAPH 6 unless specifically prohibited by federal law. By operation of law, eligible persons assign to the system and a county rights to all types of medical benefits to which the person is entitled, including first party medical benefits under automobile insurance policies based on the order of priorities established pursuant to section 36-2915. The state has a right to subrogation against any other person or firm to enforce the assignment of medical benefits. The provisions of this subsection are controlling over the provisions of any insurance policy that provides benefits to an eligible person if the policy is inconsistent with the provisions of this subsection.

G. Notwithstanding subsection E of this section, the administrator may subcontract distinct administrative functions to one or more persons who may be contractors within the system.

H. The director shall require as a condition of a contract with any contractor that all records relating to contract compliance are available for inspection by the administrator and the director subject to subsection I of this section and that such records be maintained by the contractor for five years. The director shall also require that these records be made available by a contractor on request of the secretary of the United States department of health and human services, or its successor agency.

I. Subject to existing law relating to privilege and protection, the director shall prescribe by rule the types of information that are confidential and circumstances under which such information may be used or released, including requirements for physician-patient confidentiality. Notwithstanding any other provision of law, such rules shall be designed to provide for the exchange of necessary information among the counties, the administration and the department of economic security for the purposes of eligibility determination under this article. Notwithstanding any law to the contrary, a member's medical record shall be released without the member's consent in situations or suspected cases of fraud or abuse relating to the system to an officer of the state's certified Arizona health care cost

containment system fraud control unit who has submitted a written request for the medical record.

J. The director shall prescribe rules that specify methods for:

1. The transition of members between system contractors and noncontracting providers.

2. The transfer of members and persons who have been determined eligible from hospitals that do not have contracts to care for such persons.

K. The director shall adopt rules that set forth procedures and standards for use by the system in requesting county long-term care for members or persons determined eligible.

L. To the extent that services are furnished pursuant to this article, and unless otherwise required pursuant to this chapter, a contractor is not subject to title 20.

M. As a condition of the contract with any contractor, the director shall require contract terms as necessary in the judgment of the director to ensure adequate performance and compliance with all applicable federal laws by the contractor of the provisions of each contract executed pursuant to this chapter. Contract provisions required by the director shall include at a minimum the maintenance of deposits, performance bonds, financial reserves or other financial security. The director may waive requirements for the posting of bonds or security for contractors that have posted other security, equal to or greater than that required by the system, with a state agency for the performance of health service contracts if funds would be available from such security for the system on default by the contractor. The director may also adopt rules for the withholding or forfeiture of payments to be made to a contractor by the system for the failure of the contractor to comply with a provision of the contractor's contract with the system or with the adopted rules. The director may also require contract terms allowing the administration to operate a contractor directly under circumstances specified in the contract. The administration shall operate the contractor only as long as it is necessary to assure delivery of uninterrupted care to members enrolled with the contractor and accomplish the orderly transition of those members to other system contractors, or until the contractor reorganizes or otherwise corrects the contract performance failure. The administration shall not operate a contractor unless, before that action, the administration delivers notice to the contractor and provides an opportunity for a hearing in accordance with procedures established by the director. Notwithstanding the provisions of a contract, if the administration finds that the public health, safety or welfare requires emergency action, it may operate as the contractor on notice to the contractor and pending an administrative hearing, which it shall promptly institute.

N. The administration for the sole purpose of matters concerning and directly related to the Arizona health care cost containment system and the Arizona long-term care system is exempt from section 41-192.

O. Notwithstanding subsection F of this section, if the administration determines that according to federal guidelines it is more cost-effective for a person defined as eligible under section 36-2901, paragraph 6, subdivision (a) to be enrolled in a group health insurance plan in which the person is entitled to be enrolled, the administration may pay all of that person's premiums, deductibles, coinsurance and other cost sharing obligations for services covered under section 36-2907. The person shall apply for enrollment in the group health insurance plan as a condition of eligibility under section 36-2901, paragraph 6, subdivision (a).

P. The total amount of state monies that may be spent in any fiscal year by the administration for health care shall not exceed the amount appropriated or authorized by section 35-173 for all health care purposes. This article does not impose a duty on an officer, agent or employee of this state to discharge a responsibility or to create any right in a person or group if the discharge or right would require an expenditure of state monies in excess of the expenditure authorized by legislative appropriation for that specific purpose.

Q. Notwithstanding section 36-470, a contractor or program contractor may receive laboratory tests from a laboratory or hospital-based laboratory for a system member enrolled with the contractor or program contractor subject to all of the following requirements:

1. The contractor or program contractor shall provide a written request to the laboratory in a format mutually agreed to by the laboratory and the requesting health plan or program contractor. The request shall include the member's name, the member's plan identification number, the specific test results that are being requested and the time periods and the quality improvement activity that prompted the request.

2. The laboratory data may be provided in written or electronic format based on the agreement between the laboratory and the contractor or program contractor. If there is no contract between the laboratory and the contractor or program contractor, the laboratory shall provide the requested data in a format agreed to by the noncontracted laboratory.

3. The laboratory test results provided to the member's contractor or program contractor shall only be used for quality improvement activities authorized by the administration and health care outcome studies required by the administration. The contractors and program contractors shall maintain strict confidentiality about the test results and identity of the member as specified in contractual arrangements with the administration and pursuant to state and federal law.

4. The administration, after collaboration with the department of health services regarding quality improvement activities, may prohibit the contractors and program contractors from receiving certain test results if the administration determines that a serious potential exists that the results may be used for purposes other than those intended for the quality improvement activities. The department of health services shall consult with

the clinical laboratory licensure advisory committee established by section 36-465 before providing recommendations to the administration on certain test results and quality improvement activities.

5. The administration shall provide contracted laboratories and the department of health services with an annual report listing the quality improvement activities that will require laboratory data. The report shall be updated and distributed to the contracting laboratories and the department of health services when laboratory data is needed for new quality improvement activities.

6. A laboratory that complies with a request from the contractor or program contractor for laboratory results pursuant to this section is not subject to civil liability for providing the data to the contractor or program contractor. The administration, the contractor or a program contractor that uses data for reasons other than quality improvement activities is subject to civil liability for this improper use.

R. For the purposes of this section, "quality improvement activities" means those requirements, including health care outcome studies specified in federal law or required by the centers for medicare and medicaid services or the administration, to improve health care outcomes.

Sec. 2. Section 36-2903.01, Arizona Revised Statutes, as amended by Laws 2010, seventh special session, chapter 10, section 2, is amended to read:

36-2903.01. Additional powers and duties; report

A. The director of the Arizona health care cost containment system administration may adopt rules that provide that the system may withhold or forfeit payments to be made to a noncontracting provider by the system if the noncontracting provider fails to comply with this article, the provider agreement or rules that are adopted pursuant to this article and that relate to the specific services rendered for which a claim for payment is made.

B. The director shall:

1. Prescribe uniform forms to be used by all contractors. The rules shall require a written and signed application by the applicant or an applicant's authorized representative, or, if the person is incompetent or incapacitated, a family member or a person acting responsibly for the applicant may obtain a signature or a reasonable facsimile and file the application as prescribed by the administration.

2. Enter into an interagency agreement with the department to establish a streamlined eligibility process to determine the eligibility of all persons defined pursuant to section 36-2901, paragraph 6, subdivision (a). At the administration's option, the interagency agreement may allow the administration to determine the eligibility of certain persons, including those defined pursuant to section 36-2901, paragraph 6, subdivision (a).

3. Enter into an intergovernmental agreement with the department to:

(a) Establish an expedited eligibility and enrollment process for all persons who are hospitalized at the time of application.

(b) Establish performance measures and incentives for the department.

(c) Establish the process for management evaluation reviews that the administration shall perform to evaluate the eligibility determination functions performed by the department.

(d) Establish eligibility quality control reviews by the administration.

(e) Require the department to adopt rules, consistent with the rules adopted by the administration for a hearing process, that applicants or members may use for appeals of eligibility determinations or redeterminations.

(f) Establish the department's responsibility to place sufficient eligibility workers at federally qualified health centers to screen for eligibility and at hospital sites and level one trauma centers to ensure that persons seeking hospital services are screened on a timely basis for eligibility for the system, including a process to ensure that applications for the system can be accepted on a twenty-four hour basis, seven days a week.

(g) Withhold payments based on the allowable sanctions for errors in eligibility determinations or redeterminations or failure to meet performance measures required by the intergovernmental agreement.

(h) Recoup from the department all federal fiscal sanctions that result from the department's inaccurate eligibility determinations. The director may offset all or part of a sanction if the department submits a corrective action plan and a strategy to remedy the error.

4. By rule establish a procedure and time frames for the intake of grievances and requests for hearings, for the continuation of benefits and services during the appeal process and for a grievance process at the contractor level. Notwithstanding sections 41-1092.02, 41-1092.03 and 41-1092.05, the administration shall develop rules to establish the procedure and time frame for the informal resolution of grievances and appeals. A grievance that is not related to a claim for payment of system covered services shall be filed in writing with and received by the administration or the prepaid capitated provider or program contractor not later than sixty days after the date of the adverse action, decision or policy implementation being grieved. A grievance that is related to a claim for payment of system covered services must be filed in writing and received by the administration or the prepaid capitated provider or program contractor within twelve months after the date of service, within twelve months after the date that eligibility is posted or within sixty days after the date of the denial of a timely claim submission, whichever is later. A grievance for the denial of a claim for reimbursement of services may contest the validity of any adverse action, decision, policy implementation or rule that related to or resulted

in the full or partial denial of the claim. A policy implementation may be subject to a grievance procedure, but it may not be appealed for a hearing. The administration is not required to participate in a mandatory settlement conference if it is not a real party in interest. In any proceeding before the administration, including a grievance or hearing, persons may represent themselves or be represented by a duly authorized agent who is not charging a fee. A legal entity may be represented by an officer, partner or employee who is specifically authorized by the legal entity to represent it in the particular proceeding.

5. Apply for and accept federal funds available under title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396 (1980)) in support of the system. The application made by the director pursuant to this paragraph shall be designed to qualify for federal funding primarily on a prepaid capitated basis. Such funds may be used only for the support of persons defined as eligible pursuant to title XIX of the social security act or the approved section 1115 waiver.

6. At least thirty days before the implementation of a policy or a change to an existing policy relating to reimbursement, provide notice to interested parties. Parties interested in receiving notification of policy changes shall submit a written request for notification to the administration.

7. In addition to the cost sharing requirements specified in subsection D, paragraph 4 of this section:

(a) Charge monthly premiums up to the maximum amount allowed by federal law to all populations of eligible persons who may be charged.

(b) Implement this paragraph to the extent permitted under the federal deficit reduction act of 2005 and other federal laws, subject to the approval of federal waiver authority and to the extent that any changes in the cost sharing requirements under this paragraph would permit this state to receive any enhanced federal matching rate.

C. The director is authorized to apply for any federal funds available for the support of programs to investigate and prosecute violations arising from the administration and operation of the system. Available state funds appropriated for the administration and operation of the system may be used as matching funds to secure federal funds pursuant to this subsection.

D. The director may adopt rules or procedures to do the following:

1. Authorize advance payments based on estimated liability to a contractor or a noncontracting provider after the contractor or noncontracting provider has submitted a claim for services and before the claim is ultimately resolved. The rules shall specify that any advance payment shall be conditioned on the execution before payment of a contract with the contractor or noncontracting provider that requires the administration to retain a specified percentage, which shall be at least twenty per cent, of the claimed amount as security and that requires repayment to the administration if the administration makes any overpayment.

2. Defer liability, in whole or in part, of contractors for care provided to members who are hospitalized on the date of enrollment or under other circumstances. Payment shall be on a capped fee-for-service basis for services other than hospital services and at the rate established pursuant to subsection G or H of this section for hospital services or at the rate paid by the health plan, whichever is less.

3. Deputize, in writing, any qualified officer or employee in the administration to perform any act that the director by law is empowered to do or charged with the responsibility of doing, including the authority to issue final administrative decisions pursuant to section 41-1092.08.

4. Notwithstanding any other law, require persons eligible pursuant to section 36-2901, paragraph 6, subdivision (a), ~~or~~ section 36-2931 AND SECTION 36-2981, PARAGRAPH 6 to be financially responsible for any cost sharing requirements established in a state plan or a section 1115 waiver and approved by the centers for medicare and medicaid services. Cost sharing requirements may include copayments, coinsurance, deductibles, enrollment fees and monthly premiums for enrolled members, including households with children enrolled in the Arizona long-term care system.

E. The director shall adopt rules that further specify the medical care and hospital services that are covered by the system pursuant to section 36-2907.

F. In addition to the rules otherwise specified in this article, the director may adopt necessary rules pursuant to title 41, chapter 6 to carry out this article. Rules adopted by the director pursuant to this subsection shall consider the differences between rural and urban conditions on the delivery of hospitalization and medical care.

G. For inpatient hospital admissions and all outpatient hospital services before March 1, 1993, the administration shall reimburse a hospital's adjusted billed charges according to the following procedures:

1. The director shall adopt rules that, for services rendered from and after September 30, 1985 until October 1, 1986, define "adjusted billed charges" as that reimbursement level that has the effect of holding constant whichever of the following is applicable:

(a) The schedule of rates and charges for a hospital in effect on April 1, 1984 as filed pursuant to chapter 4, article 3 of this title.

(b) The schedule of rates and charges for a hospital that became effective after May 31, 1984 but before July 2, 1984, if the hospital's previous rate schedule became effective before April 30, 1983.

(c) The schedule of rates and charges for a hospital that became effective after May 31, 1984 but before July 2, 1984, limited to five per cent over the hospital's previous rate schedule, and if the hospital's previous rate schedule became effective on or after April 30, 1983 but before October 1, 1983. For the purposes of this paragraph, "constant" means equal to or lower than.

2. The director shall adopt rules that, for services rendered from and after September 30, 1986, define "adjusted billed charges" as that reimbursement level that has the effect of increasing by four per cent a hospital's reimbursement level in effect on October 1, 1985 as prescribed in paragraph 1 of this subsection. Beginning January 1, 1991, the Arizona health care cost containment system administration shall define "adjusted billed charges" as the reimbursement level determined pursuant to this section, increased by two and one-half per cent.

3. In no event shall a hospital's adjusted billed charges exceed the hospital's schedule of rates and charges filed with the department of health services and in effect pursuant to chapter 4, article 3 of this title.

4. For services rendered the administration shall not pay a hospital's adjusted billed charges in excess of the following:

(a) If the hospital's bill is paid within thirty days of the date the bill was received, eighty-five per cent of the adjusted billed charges.

(b) If the hospital's bill is paid any time after thirty days but within sixty days of the date the bill was received, ninety-five per cent of the adjusted billed charges.

(c) If the hospital's bill is paid any time after sixty days of the date the bill was received, one hundred per cent of the adjusted billed charges.

5. The director shall define by rule the method of determining when a hospital bill will be considered received and when a hospital's billed charges will be considered paid. Payment received by a hospital from the administration pursuant to this subsection or from a contractor either by contract or pursuant to section 36-2904, subsection I shall be considered payment of the hospital bill in full, except that a hospital may collect any unpaid portion of its bill from other third party payors or in situations covered by title 33, chapter 7, article 3.

H. For inpatient hospital admissions and outpatient hospital services on and after March 1, 1993 the administration shall adopt rules for the reimbursement of hospitals according to the following procedures:

1. For inpatient hospital stays, the administration shall use a prospective tiered per diem methodology, using hospital peer groups if analysis shows that cost differences can be attributed to independently definable features that hospitals within a peer group share. In peer grouping the administration may consider such factors as length of stay differences and labor market variations. If there are no cost differences, the administration shall implement a stop loss-stop gain or similar mechanism. Any stop loss-stop gain or similar mechanism shall ensure that the tiered per diem rates assigned to a hospital do not represent less than ninety per cent of its 1990 base year costs or more than one hundred ten per cent of its 1990 base year costs, adjusted by an audit factor, during the period of March 1, 1993 through September 30, 1994. The tiered per diem rates set for hospitals shall represent no less than eighty-seven and

one-half per cent or more than one hundred twelve and one-half per cent of its 1990 base year costs, adjusted by an audit factor, from October 1, 1994 through September 30, 1995 and no less than eighty-five per cent or more than one hundred fifteen per cent of its 1990 base year costs, adjusted by an audit factor, from October 1, 1995 through September 30, 1996. For the periods after September 30, 1996 no stop loss-stop gain or similar mechanisms shall be in effect. An adjustment in the stop loss-stop gain percentage may be made to ensure that total payments do not increase as a result of this provision. If peer groups are used the administration shall establish initial peer group designations for each hospital before implementation of the per diem system. The administration may also use a negotiated rate methodology. The tiered per diem methodology may include separate consideration for specialty hospitals that limit their provision of services to specific patient populations, such as rehabilitative patients or children. The initial per diem rates shall be based on hospital claims and encounter data for dates of service November 1, 1990 through October 31, 1991 and processed through May of 1992.

2. For rates effective on October 1, 1994, and annually thereafter, the administration shall adjust tiered per diem payments for inpatient hospital care by the data resources incorporated market basket index for prospective payment system hospitals. For rates effective beginning on October 1, 1999, the administration shall adjust payments to reflect changes in length of stay for the maternity and nursery tiers.

3. Through June 30, 2004, for outpatient hospital services, the administration shall reimburse a hospital by applying a hospital specific outpatient cost-to-charge ratio to the covered charges. Beginning on July 1, 2004 through June 30, 2005, the administration shall reimburse a hospital by applying a hospital specific outpatient cost-to-charge ratio to covered charges. If the hospital increases its charges for outpatient services filed with the Arizona department of health services pursuant to chapter 4, article 3 of this title, by more than 4.7 per cent for dates of service effective on or after July 1, 2004, the hospital specific cost-to-charge ratio will be reduced by the amount that it exceeds 4.7 per cent. If charges exceed 4.7 per cent, the effective date of the increased charges will be the effective date of the adjusted Arizona health care cost containment system cost-to-charge ratio. The administration shall develop the methodology for a capped fee-for-service schedule and a statewide cost-to-charge ratio. Any covered outpatient service not included in the capped fee-for-service schedule shall be reimbursed by applying the statewide cost-to-charge ratio that is based on the services not included in the capped fee-for-service schedule. Beginning on July 1, 2005, the administration shall reimburse clean claims with dates of service on or after July 1, 2005, based on the capped fee-for-service schedule or the statewide cost-to-charge ratio established pursuant to this paragraph. The administration may make additional adjustments to the outpatient hospital rates established pursuant

to this section based on other factors, including the number of beds in the hospital, specialty services available to patients and the geographic location of the hospital.

4. Except if submitted under an electronic claims submission system, a hospital bill is considered received for purposes of this paragraph on initial receipt of the legible, error-free claim form by the administration if the claim includes the following error-free documentation in legible form:

(a) An admission face sheet.

(b) An itemized statement.

(c) An admission history and physical.

(d) A discharge summary or an interim summary if the claim is split.

(e) An emergency record, if admission was through the emergency room.

(f) Operative reports, if applicable.

(g) A labor and delivery room report, if applicable.

Payment received by a hospital from the administration pursuant to this subsection or from a contractor either by contract or pursuant to section 36-2904, subsection I is considered payment by the administration or the contractor of the administration's or contractor's liability for the hospital bill. A hospital may collect any unpaid portion of its bill from other third party payors or in situations covered by title 33, chapter 7, article 3.

5. For services rendered on and after October 1, 1997, the administration shall pay a hospital's rate established according to this section subject to the following:

(a) If the hospital's bill is paid within thirty days of the date the bill was received, the administration shall pay ninety-nine per cent of the rate.

(b) If the hospital's bill is paid after thirty days but within sixty days of the date the bill was received, the administration shall pay one hundred per cent of the rate.

(c) If the hospital's bill is paid any time after sixty days of the date the bill was received, the administration shall pay one hundred per cent of the rate plus a fee of one per cent per month for each month or portion of a month following the sixtieth day of receipt of the bill until the date of payment.

6. In developing the reimbursement methodology, if a review of the reports filed by a hospital pursuant to section 36-125.04 indicates that further investigation is considered necessary to verify the accuracy of the information in the reports, the administration may examine the hospital's records and accounts related to the reporting requirements of section 36-125.04. The administration shall bear the cost incurred in connection with this examination unless the administration finds that the records examined are significantly deficient or incorrect, in which case the administration may charge the cost of the investigation to the hospital examined.

7. Except for privileged medical information, the administration shall make available for public inspection the cost and charge data and the calculations used by the administration to determine payments under the tiered per diem system, provided that individual hospitals are not identified by name. The administration shall make the data and calculations available for public inspection during regular business hours and shall provide copies of the data and calculations to individuals requesting such copies within thirty days of receipt of a written request. The administration may charge a reasonable fee for the provision of the data or information.

8. The prospective tiered per diem payment methodology for inpatient hospital services shall include a mechanism for the prospective payment of inpatient hospital capital related costs. The capital payment shall include hospital specific and statewide average amounts. For tiered per diem rates beginning on October 1, 1999, the capital related cost component is frozen at the blended rate of forty per cent of the hospital specific capital cost and sixty per cent of the statewide average capital cost in effect as of January 1, 1999 and as further adjusted by the calculation of tier rates for maternity and nursery as prescribed by law. The administration shall adjust the capital related cost component by the data resources incorporated market basket index for prospective payment system hospitals.

9. For graduate medical education programs:

(a) Beginning September 30, 1997, the administration shall establish a separate graduate medical education program to reimburse hospitals that had graduate medical education programs that were approved by the administration as of October 1, 1999. The administration shall separately account for monies for the graduate medical education program based on the total reimbursement for graduate medical education reimbursed to hospitals by the system in federal fiscal year 1995-1996 pursuant to the tiered per diem methodology specified in this section. The graduate medical education program reimbursement shall be adjusted annually by the increase or decrease in the index published by the global insight hospital market basket index for prospective hospital reimbursement. Subject to legislative appropriation, on an annual basis, each qualified hospital shall receive a single payment from the graduate medical education program that is equal to the same percentage of graduate medical education reimbursement that was paid by the system in federal fiscal year 1995-1996. Any reimbursement for graduate medical education made by the administration shall not be subject to future settlements or appeals by the hospitals to the administration. The monies available under this subdivision shall not exceed the fiscal year 2005-2006 appropriation adjusted annually by the increase or decrease in the index published by the global insight hospital market basket index for prospective hospital reimbursement, except for monies distributed for expansions pursuant to subdivision (b) of this paragraph.

(b) The monies available for graduate medical education programs pursuant to this subdivision shall not exceed the fiscal year 2006-2007

appropriation adjusted annually by the increase or decrease in the index published by the global insight hospital market basket index for prospective hospital reimbursement. Graduate medical education programs eligible for such reimbursement are not precluded from receiving reimbursement for funding under subdivision (c) of this paragraph. Beginning July 1, 2006, the administration shall distribute any monies appropriated for graduate medical education above the amount prescribed in subdivision (a) of this paragraph in the following order or priority:

(i) For the direct costs to support the expansion of graduate medical education programs established before July 1, 2006 at hospitals that do not receive payments pursuant to subdivision (a) of this paragraph. These programs must be approved by the administration.

(ii) For the direct costs to support the expansion of graduate medical education programs established on or before October 1, 1999. These programs must be approved by the administration.

(c) The administration shall distribute to hospitals any monies appropriated for graduate medical education above the amount prescribed in subdivisions (a) and (b) of this paragraph for the following purposes:

(i) For the direct costs of graduate medical education programs established or expanded on or after July 1, 2006. These programs must be approved by the administration.

(ii) For a portion of additional indirect graduate medical education costs for programs that are located in a county with a population of less than five hundred thousand persons at the time the residency position was created or for a residency position that includes a rotation in a county with a population of less than five hundred thousand persons at the time the residency position was established. These programs must be approved by the administration.

(d) The administration shall develop, by rule, the formula by which the monies are distributed.

(e) Each graduate medical education program that receives funding pursuant to subdivision (b) or (c) of this paragraph shall identify and report to the administration the number of new residency positions created by the funding provided in this paragraph, including positions in rural areas. The program shall also report information related to the number of funded residency positions that resulted in physicians locating their practice in this state. The administration shall report to the joint legislative budget committee by February 1 of each year on the number of new residency positions as reported by the graduate medical education programs.

(f) Beginning July 1, 2007, local, county and tribal governments may provide monies in addition to any state general fund monies appropriated for graduate medical education in order to qualify for additional matching federal monies for programs or positions in a specific locality and costs incurred pursuant to a specific contract between the administration and providers or other entities to provide graduate medical education services as

an administrative activity. These programs, positions and administrative graduate medical education services must be approved by the administration and the centers for medicare and medicaid services. The administration shall report to the president of the senate, the speaker of the house of representatives and the director of the joint legislative budget committee on or before July 1 of each year on the amount of money contributed and number of residency positions funded by local, county and tribal governments, including the amount of federal matching monies used.

(g) Any funds appropriated but not allocated by the administration for subdivision (b) or (c) of this paragraph may be reallocated if funding for either subdivision is insufficient to cover appropriate graduate medical education costs.

(h) For the purposes of this paragraph, "graduate medical education program" means a program, including an approved fellowship, that prepares a physician for the independent practice of medicine by providing didactic and clinical education in a medical discipline to a medical student who has completed a recognized undergraduate medical education program.

10. The prospective tiered per diem payment methodology for inpatient hospital services shall include a mechanism for the payment of claims with extraordinary operating costs per day. For tiered per diem rates effective beginning on October 1, 1999, outlier cost thresholds are frozen at the levels in effect on January 1, 1999 and adjusted annually by the administration by the global insight hospital market basket index for prospective payment system hospitals. Beginning with dates of service on or after October 1, 2007, the administration shall phase in the use of the most recent statewide urban and statewide rural average medicare cost-to-charge ratios or centers for medicare and medicaid services approved cost-to-charge ratios to qualify and pay extraordinary operating costs. Cost-to-charge ratios shall be updated annually. Routine maternity charges are not eligible for outlier reimbursement. The administration shall complete full implementation of the phase-in on or before October 1, 2009.

11. Notwithstanding section 41-1005, subsection A, paragraph 9, the administration shall adopt rules pursuant to title 41, chapter 6 establishing the methodology for determining the prospective tiered per diem payments.

I. The director may adopt rules that specify enrollment procedures, including notice to contractors of enrollment. The rules may provide for varying time limits for enrollment in different situations. The administration shall specify in contract when a person who has been determined eligible will be enrolled with that contractor and the date on which the contractor will be financially responsible for health and medical services to the person.

J. The administration may make direct payments to hospitals for hospitalization and medical care provided to a member in accordance with this article and rules. The director may adopt rules to establish the procedures by which the administration shall pay hospitals pursuant to this subsection

if a contractor fails to make timely payment to a hospital. Such payment shall be at a level determined pursuant to section 36-2904, subsection H or I. The director may withhold payment due to a contractor in the amount of any payment made directly to a hospital by the administration on behalf of a contractor pursuant to this subsection.

K. The director shall establish a special unit within the administration for the purpose of monitoring the third party payment collections required by contractors and noncontracting providers pursuant to section 36-2903, subsection B, paragraph 10 and subsection F and section 36-2915, subsection E. The director shall determine by rule:

1. The type of third party payments to be monitored pursuant to this subsection.

2. The percentage of third party payments that is collected by a contractor or noncontracting provider and that the contractor or noncontracting provider may keep and the percentage of such payments that the contractor or noncontracting provider may be required to pay to the administration. Contractors and noncontracting providers must pay to the administration one hundred per cent of all third party payments that are collected and that duplicate administration fee-for-service payments. A contractor that contracts with the administration pursuant to section 36-2904, subsection A may be entitled to retain a percentage of third party payments if the payments collected and retained by a contractor are reflected in reduced capitation rates. A contractor may be required to pay the administration a percentage of third party payments that are collected by a contractor and that are not reflected in reduced capitation rates.

L. The administration shall establish procedures to apply to the following if a provider that has a contract with a contractor or noncontracting provider seeks to collect from an individual or financially responsible relative or representative a claim that exceeds the amount that is reimbursed or should be reimbursed by the system:

1. On written notice from the administration or oral or written notice from a member that a claim for covered services may be in violation of this section, the provider that has a contract with a contractor or noncontracting provider shall investigate the inquiry and verify whether the person was eligible for services at the time that covered services were provided. If the claim was paid or should have been paid by the system, the provider that has a contract with a contractor or noncontracting provider shall not continue billing the member.

2. If the claim was paid or should have been paid by the system and the disputed claim has been referred for collection to a collection agency or referred to a credit reporting bureau, the provider that has a contract with a contractor or noncontracting provider shall:

(a) Notify the collection agency and request that all attempts to collect this specific charge be terminated immediately.

(b) Advise all credit reporting bureaus that the reported delinquency was in error and request that the affected credit report be corrected to remove any notation about this specific delinquency.

(c) Notify the administration and the member that the request for payment was in error and that the collection agency and credit reporting bureaus have been notified.

3. If the administration determines that a provider that has a contract with a contractor or noncontracting provider has billed a member for charges that were paid or should have been paid by the administration, the administration shall send written notification by certified mail or other service with proof of delivery to the provider that has a contract with a contractor or noncontracting provider stating that this billing is in violation of federal and state law. If, twenty-one days or more after receiving the notification, a provider that has a contract with a contractor or noncontracting provider knowingly continues billing a member for charges that were paid or should have been paid by the system, the administration may assess a civil penalty in an amount equal to three times the amount of the billing and reduce payment to the provider that has a contract with a contractor or noncontracting provider accordingly. Receipt of delivery signed by the addressee or the addressee's employee is prima facie evidence of knowledge. Civil penalties collected pursuant to this subsection shall be deposited in the state general fund. Section 36-2918, subsections C, D and F, relating to the imposition, collection and enforcement of civil penalties, apply to civil penalties imposed pursuant to this paragraph.

M. The administration may conduct postpayment review of all claims paid by the administration and may recoup any monies erroneously paid. The director may adopt rules that specify procedures for conducting postpayment review. A contractor may conduct a postpayment review of all claims paid by the contractor and may recoup monies that are erroneously paid.

N. The director or the director's designee may employ and supervise personnel necessary to assist the director in performing the functions of the administration.

O. The administration may contract with contractors for obstetrical care who are eligible to provide services under title XIX of the social security act.

P. Notwithstanding any other law, on federal approval the administration may make disproportionate share payments to private hospitals, county operated hospitals, including hospitals owned or leased by a special health care district, and state operated institutions for mental disease beginning October 1, 1991 in accordance with federal law and subject to legislative appropriation. If at any time the administration receives written notification from federal authorities of any change or difference in the actual or estimated amount of federal funds available for disproportionate share payments from the amount reflected in the legislative appropriation for such purposes, the administration shall provide written

notification of such change or difference to the president and the minority leader of the senate, the speaker and the minority leader of the house of representatives, the director of the joint legislative budget committee, the legislative committee of reference and any hospital trade association within this state, within three working days not including weekends after receipt of the notice of the change or difference. In calculating disproportionate share payments as prescribed in this section, the administration may use either a methodology based on claims and encounter data that is submitted to the administration from contractors or a methodology based on data that is reported to the administration by private hospitals and state operated institutions for mental disease. The selected methodology applies to all private hospitals and state operated institutions for mental disease qualifying for disproportionate share payments.

Q. Notwithstanding any law to the contrary, the administration may receive confidential adoption information to determine whether an adopted child should be terminated from the system.

R. The adoption agency or the adoption attorney shall notify the administration within thirty days after an eligible person receiving services has placed that person's child for adoption.

S. If the administration implements an electronic claims submission system, it may adopt procedures pursuant to subsection H of this section requiring documentation different than prescribed under subsection H, paragraph 4 of this section.

Sec. 3. Section 36-2905, Arizona Revised Statutes, as amended by Laws 2010, seventh special session, chapter 10, section 3, is amended to read:

36-2905. Removal of medicaid special exemption for payments to contractors; civil penalty

A. Notwithstanding any other law, beginning on October 1, 2003, each contractor shall pay to the director of the department of insurance a tax equal to two per cent of the total capitation, including reinsurance, and any other reimbursement paid to the contractor by the administration for persons eligible pursuant to section 36-2901, paragraph 6, subdivisions (a) and (g) AND ARTICLE 4 OF THIS CHAPTER. The tax shall be paid in four payments pursuant to subsection C of this section and deposited in the state general fund pursuant to sections 35-146 and 35-147.

B. The contractor shall not deduct any disallowance or penalty imposed by the administration pursuant to this chapter from the financial information submitted to the director of the department of insurance.

C. Each contractor shall file the estimated tax and documentation with the director of the department of insurance on a form prescribed by the director of the department of insurance to pay the estimated tax. A contractor shall make estimated tax payments to the director of the department of insurance for deposit in the state general fund pursuant to sections 35-146 and 35-147. The tax payments are due on or before September 15, December 15, March 15 and June 15 of each year. The amount of the

payments shall be an estimate of the tax due for the quarter that ends in the month that payment is due.

D. On or before April 1, 2004 and annually on or before April 1 thereafter, the director of the department of insurance shall use data provided by the administration to reconcile the amount paid by each contractor pursuant to this section with the actual amount of title XIX AND TITLE XXI reimbursement made by the administration to the contractor in the preceding calendar year. If there is a discrepancy in the two amounts, the director of the department of insurance shall notify the contractor of the difference, provide a notice of right of appeal and bill the contractor for the unpaid amount of the premium tax or, if there is an overpayment, the director of the department of insurance shall either refund the amount of the overpayment to the contractor or issue a credit for the amount of the overpayment that the contractor can apply against future tax obligations prescribed by this section.

E. A contractor who fails to file an estimated payment or pay an unpaid premium tax as prescribed by this section is subject to a civil penalty equal to the greater of twenty-five dollars or five per cent of the amount due and is subject to interest on the amount due at the rate of one per cent per month from the date the amount was due.

Sec. 4. Section 36-2905.08, Arizona Revised Statutes, as amended by Laws 2010, seventh special session, chapter 10, section 4, is amended to read:

36-2905.08. Nicotine replacement therapies; tobacco use medications

A. NOTWITHSTANDING SECTION 36-2989, for contract years beginning October 1, 2008, the administration may expend monies to provide nicotine replacement therapies and tobacco use medications to members eligible pursuant to this article or article 2 or 3 of this chapter.

B. The administration shall not use monies from the state general fund for the purposes of this section.

Sec. 5. Section 36-2907, Arizona Revised Statutes, as amended by Laws 2010, seventh special session, chapter 10, section 5, is amended to read:

36-2907. Covered health and medical services; modifications; related delivery of service requirements

A. Subject to the limitations and exclusions specified in this section, contractors shall provide the following medically necessary health and medical services:

1. Inpatient hospital services that are ordinarily furnished by a hospital for the care and treatment of inpatients and that are provided under the direction of a physician or a primary care practitioner. For the purposes of this section, inpatient hospital services exclude services in an institution for tuberculosis or mental diseases unless authorized under an approved section 1115 waiver.

2. Outpatient health services that are ordinarily provided in hospitals, clinics, offices and other health care facilities by licensed health care providers. Outpatient health services include services provided by or under the direction of a physician or a primary care practitioner.

3. Other laboratory and x-ray services ordered by a physician or a primary care practitioner.

4. Medications that are ordered on prescription by a physician or a dentist licensed pursuant to title 32, chapter 11. Beginning January 1, 2006, persons who are dually eligible for title XVIII and title XIX services must obtain available medications through a medicare licensed or certified medicare advantage prescription drug plan, a medicare prescription drug plan or any other entity authorized by medicare to provide a medicare part D prescription drug benefit.

5. Medical supplies, durable medical equipment and prosthetic devices ordered by a physician or a primary care practitioner. Suppliers of durable medical equipment shall provide the administration with complete information about the identity of each person who has an ownership or controlling interest in their business and shall comply with federal bonding requirements in a manner prescribed by the administration.

6. For persons who are at least twenty-one years of age, treatment of medical conditions of the eye, excluding eye examinations for prescriptive lenses and the provision of prescriptive lenses.

7. Early and periodic health screening and diagnostic services as required by section 1905(r) of title XIX of the social security act for members who are under twenty-one years of age.

8. Family planning services that do not include abortion or abortion counseling. If a contractor elects not to provide family planning services, this election does not disqualify the contractor from delivering all other covered health and medical services under this chapter. In that event, the administration may contract directly with another contractor, including an outpatient surgical center or a noncontracting provider, to deliver family planning services to a member who is enrolled with the contractor that elects not to provide family planning services.

9. Podiatry services ordered by a primary care physician or primary care practitioner.

10. Nonexperimental transplants approved for title XIX reimbursement.

11. Ambulance and nonambulance transportation, except as provided in subsection G of this section.

B. The limitations and exclusions for health and medical services provided under this section are as follows:

1. Beginning on October 1, 2002, circumcision of newborn males is not a covered health and medical service.

2. For eligible persons who are at least twenty-one years of age:

(a) Outpatient health services do not include occupational therapy or speech therapy.

(b) Prosthetic devices do not include hearing aids, dentures, bone anchored hearing aids or cochlear implants. Prosthetic devices, except prosthetic implants, may be limited to twelve thousand five-hundred dollars per contract year.

(c) Insulin pumps, percussive vests and orthotics are not covered health and medical services.

(d) Durable medical equipment is limited to items covered by medicare.

(e) Podiatry services do not include services performed by a podiatrist.

(f) Nonexperimental transplants do not include the following:

(i) Pancreas only transplants.

(ii) Pancreas after kidney transplants.

(iii) Lung transplants.

(iv) Hemopoetic cell ~~transplants.~~

~~(v)~~ allogenic unrelated transplants.

~~(vi)~~ (v) Heart transplants for non-ischemic cardiomyopathy.

~~(vii)~~ (vi) Liver transplants for diagnosis of hepatitis C.

(g) Beginning October 1, 2011, bariatric surgery procedures, including laparoscopic and open gastric bypass and restrictive procedures, are not covered health and medical services.

(h) Well exams are not a covered health and medical service, except mammograms, pap smears and colonoscopies.

C. The system shall pay noncontracting providers only for health and medical services as prescribed in subsection A of this section and as prescribed by rule.

D. The director shall adopt rules necessary to limit, to the extent possible, the scope, duration and amount of services, including maximum limitations for inpatient services that are consistent with federal regulations under title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396 (1980)). To the extent possible and practicable, these rules shall provide for the prior approval of medically necessary services provided pursuant to this chapter.

E. The director shall make available home health services in lieu of hospitalization pursuant to contracts awarded under this article. For the purposes of this subsection, "home health services" means the provision of nursing services, home health aide services or medical supplies, equipment and appliances, which are provided on a part-time or intermittent basis by a licensed home health agency within a member's residence based on the orders of a physician or a primary care practitioner. Home health agencies shall comply with the federal bonding requirements in a manner prescribed by the administration.

F. The director shall adopt rules for the coverage of behavioral health services for persons who are eligible under section 36-2901, paragraph 6, subdivision (a). The administration shall contract with the department of health services for the delivery of all medically necessary behavioral health

services to persons who are eligible under rules adopted pursuant to this subsection. The division of behavioral health in the department of health services shall establish a diagnostic and evaluation program to which other state agencies shall refer children who are not already enrolled pursuant to this chapter and who may be in need of behavioral health services. In addition to an evaluation, the division of behavioral health shall also identify children who may be eligible under section 36-2901, paragraph 6, subdivision (a) or section 36-2931, paragraph 5 and shall refer the children to the appropriate agency responsible for making the final eligibility determination.

G. The director shall adopt rules for the provision of transportation services and rules providing for copayment by members for transportation for other than emergency purposes. Subject to approval by the centers for medicare and medicaid services, nonemergency medical transportation shall not be provided to persons who are eligible pursuant to sections 36-2901.01 and 36-2901.04 and who reside in a county with a population of more than five hundred thousand persons. Prior authorization is not required for medically necessary ambulance transportation services rendered to members or eligible persons initiated by dialing telephone number 911 or other designated emergency response systems.

H. The director may adopt rules to allow the administration, at the director's discretion, to use a second opinion procedure under which surgery may not be eligible for coverage pursuant to this chapter without documentation as to need by at least two physicians or primary care practitioners.

I. If the director does not receive bids within the amounts budgeted or if at any time the amount remaining in the Arizona health care cost containment system fund is insufficient to pay for full contract services for the remainder of the contract term, the administration, on notification to system contractors at least thirty days in advance, may modify the list of services required under subsection A of this section for persons defined as eligible other than those persons defined pursuant to section 36-2901, paragraph 6, subdivision (a). The director may also suspend services or may limit categories of expense for services defined as optional pursuant to title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396 (1980)) for persons defined pursuant to section 36-2901, paragraph 6, subdivision (a). Such reductions or suspensions do not apply to the continuity of care for persons already receiving these services.

J. Additional, reduced or modified hospitalization and medical care benefits may be provided under the system to enrolled members who are eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e).

K. All health and medical services provided under this article shall be provided in the geographic service area of the member, except:

1. Emergency services and specialty services provided pursuant to section 36-2908.

2. That the director may permit the delivery of health and medical services in other than the geographic service area in this state or in an adjoining state if the director determines that medical practice patterns justify the delivery of services or a net reduction in transportation costs can reasonably be expected. Notwithstanding the definition of physician as prescribed in section 36-2901, if services are procured from a physician or primary care practitioner in an adjoining state, the physician or primary care practitioner shall be licensed to practice in that state pursuant to licensing statutes in that state similar to title 32, chapter 13, 15, 17 or 25 and shall complete a provider agreement for this state.

L. Covered outpatient services shall be subcontracted by a primary care physician or primary care practitioner to other licensed health care providers to the extent practicable for purposes including, but not limited to, making health care services available to underserved areas, reducing costs of providing medical care and reducing transportation costs.

M. The director shall adopt rules that prescribe the coordination of medical care for persons who are eligible for system services. The rules shall include provisions for the transfer of patients, the transfer of medical records and the initiation of medical care.

Sec. 6. Section 36-2912, Arizona Revised Statutes, as amended by Laws 2010, seventh special session, chapter 10, section 9, is amended to read:

36-2912. Healthcare group coverage; program requirements for small businesses and public employers; related requirements; definitions

A. The administration shall administer a healthcare group program to allow willing contractors to deliver health care services to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). In counties with a population of less than five hundred thousand persons, the administration may contract directly with any health care provider or entity. The administration may enter into a contract with another entity to provide administrative functions for the healthcare group program.

B. Employers with two eligible employees or up to an average of fifty eligible employees under section 36-2901, paragraph 6, subdivision (d):

1. May contract with the administration to be the exclusive health benefit plan if the employer has five or fewer eligible employees and enrolls one hundred per cent of these employees into the health benefit plan.

2. May contract with the administration for coverage available pursuant to this section if the employer has six or more eligible employees and enrolls eighty per cent of these employees into the healthcare group program.

3. Shall have a minimum of two and a maximum of fifty eligible employees at the effective date of their first contract with the administration.

C. The administration shall not enroll an employer group in healthcare group sooner than ninety days after the date that the employer's health insurance coverage under an accountable health plan is discontinued. Enrollment in healthcare group is effective on the first day of the month after the ninety day period. This subsection does not apply to an employer group if the employer's accountable health plan discontinues offering the health plan of which the employer is a member.

D. Employees with proof of other existing health care coverage who elect not to participate in the healthcare group program shall not be considered when determining the percentage of enrollment requirements under subsection B of this section if either:

1. Group health coverage is provided through a spouse, parent or legal guardian, or insured through individual insurance or another employer.

2. Medical assistance is provided by a government subsidized health care program.

3. MEDICAL ASSISTANCE IS PROVIDED PURSUANT TO SECTION 36-2982, SUBSECTION I.

E. An employer shall not offer coverage made available pursuant to this section to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e) as a substitute for a federally designated plan.

F. An employee or dependent defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e) may participate in healthcare group on a voluntary basis only.

G. Notwithstanding subsection B, paragraph 2 of this section, the administration shall adopt rules to allow a business that offers healthcare group coverage pursuant to this section to continue coverage if it expands its employment to include more than fifty employees.

H. The administration shall provide eligible employees with disclosure information about the health benefit plan.

I. The director shall:

1. Require that any contractor that provides covered services to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (a) provide separate audited reports on the assets, liabilities and financial status of any corporate activity involving providing coverage pursuant to this section to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e).

2. Prohibit the administration and program contractors from reimbursing a noncontracting hospital for services provided to a member at a noncontracting hospital except for services for an emergency medical condition.

3. Require that a contractor, the administration or an accountable health plan negotiate reimbursement rates. The reimbursement rate for an emergency medical condition for a noncontracting hospital is:

(a) In counties with a population of more than five hundred thousand persons, one hundred fourteen per cent of the reimbursement rates established pursuant to section 36-2903.01, subsection H. The hospital shall notify the contractor when a member is stabilized.

(b) In counties with a population of less than five hundred thousand persons, one hundred twenty-five per cent of the reimbursement rates established pursuant to section 36-2903.01, subsection H. The hospital shall notify the contractor when a member is stabilized.

4. Use monies from the healthcare group fund established by section 36-2912.01 for the administration's costs of operating the healthcare group program.

5. Ensure that the contractors are required to meet contract terms as are necessary in the judgment of the director to ensure adequate performance by the contractor. Contract provisions shall include, at a minimum, the maintenance of deposits, performance bonds, financial reserves or other financial security. The director may waive requirements for the posting of bonds or security for contractors that have posted other security, equal to or greater than that required for the healthcare group program, with the administration or the department of insurance for the performance of health service contracts if funds would be available to the administration from the other security on the contractor's default. In waiving, or approving waivers of, any requirements established pursuant to this section, the director shall ensure that the administration has taken into account all the obligations to which a contractor's security is associated. The director may also adopt rules that provide for the withholding or forfeiture of payments to be made to a contractor for the failure of the contractor to comply with provisions of its contract or with provisions of adopted rules.

6. Adopt rules.

7. Provide reinsurance to the contractors for clean claims based on thresholds established by the administration. For the purposes of this paragraph, "clean claims" has the same meaning prescribed in section 36-2904.

J. With respect to services provided by contractors to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e), a contractor is the payor of last resort and has the same lien or subrogation rights as those held by health care services organizations licensed pursuant to title 20, chapter 4, article 9.

K. The administration shall offer a health benefit plan on a guaranteed issuance basis to small employers as required by this section. All small employers qualify for this guaranteed offer of coverage. The administration shall offer to all small employers the available health benefit plan and shall accept any small employer that applies and meets the eligibility requirements. In addition to the requirements prescribed in this

section, for any offering of any health benefit plan to a small employer, as part of the administration's solicitation and sales materials, the administration shall make a reasonable disclosure to the employer of the availability of the information described in this subsection and, on request of the employer, shall provide that information to the employer. The administration shall provide information concerning the following:

1. Provisions of coverage relating to the following, if applicable:

(a) The administration's right to establish premiums and to change premium rates and the factors that may affect changes in premium rates.

(b) Renewability of coverage.

(c) Any preexisting condition exclusion.

(d) The geographic areas served by the contractor.

2. The benefits and premiums available under all health benefit plans for which the employer is qualified.

L. The administration shall describe the information required by subsection K of this section in language that is understandable by the average small employer and with a level of detail that is sufficient to reasonably inform a small employer of the employer's rights and obligations under the health benefit plan. This requirement is satisfied if the administration provides the following information:

1. An outline of coverage that describes the benefits in summary form.

2. The rate or rating schedule that applies to the product, preexisting condition exclusion or affiliation period.

3. The minimum employer contribution and group participation rules that apply to any particular type of coverage.

4. In the case of a network plan, a map or listing of the areas served.

M. A contractor is not required to disclose any information that is proprietary and protected trade secret information under applicable law.

N. At least sixty days before the date of expiration of a health benefit plan, the administration shall provide a written notice to the employer of the terms for renewal of the plan.

O. The administration shall increase or decrease premiums based on actuarial reviews by an independent actuary of the projected and actual costs of providing health care benefits to eligible members. Before changing premiums, the administration must give sixty days' written notice to the employer. For each contract period the administration shall set premiums that in the aggregate cover projected medical and administrative costs for that contract period and that are determined pursuant to generally accepted actuarial principles and practices by an independent actuary.

P. The administration shall consider age, sex, health status-related factors, group size, geographic area and community rating when it establishes premiums for the healthcare group program.

Q. Except as provided in subsection R of this section, a health benefit plan may not deny, limit or condition the coverage or benefits based

on a person's health status-related factors or a lack of evidence of insurability. A health benefit plan shall not provide or offer any service, benefit or coverage that is not part of the health benefit plan contract.

R. A health benefit plan shall not exclude coverage for preexisting conditions, except that:

1. A health benefit plan may exclude coverage for preexisting conditions for a period of not more than twelve months or, in the case of a late enrollee, eighteen months. The exclusion of coverage does not apply to services that are furnished to newborns who were otherwise covered from the time of their birth or to persons who satisfy the portability requirements under this section.

2. The contractor shall reduce the period of any applicable preexisting condition exclusion by the aggregate of the periods of creditable coverage that apply to the individual.

S. The contractor shall calculate creditable coverage according to the following:

1. The contractor shall give an individual credit for each portion of each month the individual was covered by creditable coverage.

2. The contractor shall not count a period of creditable coverage for an individual enrolled in a health benefit plan if after the period of coverage and before the enrollment date there were sixty-three consecutive days during which the individual was not covered under any creditable coverage.

3. The contractor shall give credit in the calculation of creditable coverage for any period that an individual is in a waiting period for any health coverage.

T. The contractor shall not count a period of creditable coverage with respect to enrollment of an individual if, after the most recent period of creditable coverage and before the enrollment date, sixty-three consecutive days lapse during all of which the individual was not covered under any creditable coverage. The contractor shall not include in the determination of the period of continuous coverage described in this section any period that an individual is in a waiting period for health insurance coverage offered by a health care insurer or is in a waiting period for benefits under a health benefit plan offered by a contractor. In determining the extent to which an individual has satisfied any portion of any applicable preexisting condition period the contractor shall count a period of creditable coverage without regard to the specific benefits covered during that period. A contractor shall not impose any preexisting condition exclusion in the case of an individual who is covered under creditable coverage thirty-one days after the individual's date of birth. A contractor shall not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before age eighteen and who is covered under creditable coverage thirty-one days after the adoption or placement for adoption.

U. The written certification provided by the administration must include:

1. The period of creditable coverage of the individual under the contractor and any applicable coverage under a COBRA continuation provision.

2. Any applicable waiting period or affiliation period imposed on an individual for any coverage under the health plan.

V. The administration shall issue and accept a written certification of the period of creditable coverage of the individual that contains at least the following information:

1. The date that the certificate is issued.

2. The name of the individual or dependent for whom the certificate applies and any other information that is necessary to allow the issuer providing the coverage specified in the certificate to identify the individual, including the individual's identification number under the policy and the name of the policyholder if the certificate is for or includes a dependent.

3. The name, address and telephone number of the issuer providing the certificate.

4. The telephone number to call for further information regarding the certificate.

5. One of the following:

(a) A statement that the individual has at least eighteen months of creditable coverage. For the purposes of this subdivision, "eighteen months" means five hundred forty-six days.

(b) Both the date that the individual first sought coverage, as evidenced by a substantially complete application, and the date that creditable coverage began.

6. The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing from the date of the certificate.

W. The administration shall provide any certification pursuant to this section within thirty days after the event that triggered the issuance of the certification. Periods of creditable coverage for an individual are established by presentation of the certifications in this section.

X. The healthcare group program shall comply with all applicable federal requirements.

Y. Healthcare group may pay a commission to an insurance producer. To receive a commission, the producer must certify that to the best of the producer's knowledge the employer group has not had insurance in the ninety days before applying to healthcare group. For the purposes of this subsection, "commission" means a one time payment on the initial enrollment of an employer.

Z. On or before June 15 and November 15 of each year, the director shall submit a report to the joint legislative budget committee regarding the number and type of businesses participating in healthcare group and that

includes updated information on healthcare group marketing activities. The director, within thirty days of implementation, shall notify the joint legislative budget committee of any changes in healthcare group benefits or cost sharing arrangements.

AA. The administration shall submit the following to the joint legislative budget committee:

1. Quarterly reports regarding the financial condition of the healthcare group program. The reports shall include the number of persons and employer groups enrolled in the program and medical loss information and projections.

2. An annual financial audit.

3. The analysis that is used to determine premiums pursuant to subsection O of this section.

BB. Beginning July 1, 2009, and each fiscal year thereafter, healthcare group shall limit employer group enrollment to not more than five per cent more than the number of employer groups enrolled in the program at the end of the preceding fiscal year. Healthcare group shall give enrollment priority to uninsured groups.

CC. For the purposes of this section:

1. "Accountable health plan" has the same meaning prescribed in section 20-2301.

2. "COBRA continuation provision" means:

(a) Section 4980B, except subsection (f)(1) as it relates to pediatric vaccines, of the internal revenue code of 1986.

(b) Title I, subtitle B, part 6, except section 609, of the employee retirement income security act of 1974.

(c) Title XXII of the public health service act.

(d) Any similar provision of the law of this state or any other state.

3. "Creditable coverage" means coverage solely for an individual, other than limited benefits coverage, under any of the following:

(a) An employee welfare benefit plan that provides medical care to employees or the employees' dependents directly or through insurance, reimbursement or otherwise pursuant to the employee retirement income security act of 1974.

(b) A church plan as defined in the employee retirement income security act of 1974.

(c) A health benefits plan, as defined in section 20-2301, issued by a health plan.

(d) Part A or part B of title XVIII of the social security act.

(e) Title XIX of the social security act, other than coverage consisting solely of benefits under section 1928.

(f) Title 10, chapter 55 of the United States Code.

(g) A medical care program of the Indian health service or of a tribal organization.

(h) A health benefits risk pool operated by any state of the United States.

(i) A health plan offered pursuant to title 5, chapter 89 of the United States Code.

(j) A public health plan as defined by federal law.

(k) A health benefit plan pursuant to section 5(e) of the peace corps act (22 United States Code section 2504(e)).

(l) A policy or contract, including short-term limited duration insurance, issued on an individual basis by an insurer, a health care services organization, a hospital service corporation, a medical service corporation or a hospital, medical, dental and optometric service corporation or made available to persons defined as eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e).

(m) A policy or contract issued by a health care insurer or the administration to a member of a bona fide association.

4. "Eligible employee" means a person who is one of the following:

(a) Eligible pursuant to section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e).

(b) A person who works for an employer for a minimum of twenty hours per week or who is self-employed for at least twenty hours per week.

(c) An employee who elects coverage pursuant to section 36-2982, subsection I. The restriction prohibiting employees employed by public agencies prescribed in section 36-2982, subsection I does not apply to this subdivision.

(d) A person who meets all of the eligibility requirements, who is eligible for a federal health coverage tax credit pursuant to section 35 of the internal revenue code of 1986 and who applies for health care coverage through the healthcare group program. The requirement that a person be employed with a small business that elects healthcare group coverage does not apply to this eligibility group.

5. "Emergency medical condition" has the same meaning prescribed in the emergency medical treatment and active labor act (P.L. 99-272; 100 Stat. 164; 42 United States Code section 1395dd(e)).

6. "Genetic information" means information about genes, gene products and inherited characteristics that may derive from the individual or a family member, including information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analyses of genes or chromosomes.

7. "Health benefit plan" means coverage offered by the administration for the healthcare group program pursuant to this section.

8. "Health status-related factor" means any factor in relation to the health of the individual or a dependent of the individual enrolled or to be enrolled in a health plan including:

(a) Health status.

(b) Medical condition, including physical and mental illness.
(c) Claims experience.
(d) Receipt of health care.
(e) Medical history.
(f) Genetic information.
(g) Evidence of insurability, including conditions arising out of acts of domestic violence as defined in section 20-448.
(h) The existence of a physical or mental disability.

9. "Hospital" means a health care institution licensed as a hospital pursuant to chapter 4, article 2 of this title.

10. "Late enrollee" means an employee or dependent who requests enrollment in a health benefit plan after the initial enrollment period that is provided under the terms of the health benefit plan if the initial enrollment period is at least thirty-one days. Coverage for a late enrollee begins on the date the person becomes a dependent if a request for enrollment is received within thirty-one days after the person becomes a dependent. An employee or dependent shall not be considered a late enrollee if:

(a) The person:

(i) At the time of the initial enrollment period was covered under a public or private health insurance policy or any other health benefit plan.

(ii) Lost coverage under a public or private health insurance policy or any other health benefit plan due to the employee's termination of employment or eligibility, the reduction in the number of hours of employment, the termination of the other plan's coverage, the death of the spouse, legal separation or divorce or the termination of employer contributions toward the coverage.

(iii) Requests enrollment within thirty-one days after the termination of creditable coverage that is provided under a COBRA continuation provision.

(iv) Requests enrollment within thirty-one days after the date of marriage.

(b) The person is employed by an employer that offers multiple health benefit plans and the person elects a different plan during an open enrollment period.

(c) The person becomes a dependent of an eligible person through marriage, birth, adoption or placement for adoption and requests enrollment no later than thirty-one days after becoming a dependent.

11. "Preexisting condition" means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within not more than six months before the date of the enrollment of the individual under a health benefit plan issued by a contractor. Preexisting condition does not include a genetic condition in the absence of a diagnosis of the condition related to the genetic information.

12. "Preexisting condition limitation" or "preexisting condition exclusion" means a limitation or exclusion of benefits for a preexisting condition under a health benefit plan offered by a contractor.

13. "Small employer" means an employer who employs at least one but not more than fifty eligible employees on a typical business day during any one calendar year.

14. "Waiting period" means the period that must pass before a potential participant or eligible employee in a health benefit plan offered by a health plan is eligible to be covered for benefits as determined by the individual's employer.

Sec. 7. Title 36, chapter 29, Arizona Revised Statutes, is amended by adding article 4, to read:

ARTICLE 4. CHILDREN'S HEALTH INSURANCE PROGRAM

36-2981. Definitions

IN THIS ARTICLE, UNLESS THE CONTEXT OTHERWISE REQUIRES:

1. "ADMINISTRATION" MEANS THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION.

2. "CONTRACTOR" MEANS A HEALTH PLAN THAT CONTRACTS WITH THE ADMINISTRATION FOR THE PROVISION OF HOSPITALIZATION AND MEDICAL CARE TO MEMBERS ACCORDING TO THE PROVISIONS OF THIS ARTICLE OR A QUALIFYING PLAN.

3. "DIRECTOR" MEANS THE DIRECTOR OF THE ADMINISTRATION.

4. "FEDERAL POVERTY LEVEL" MEANS THE FEDERAL POVERTY LEVEL GUIDELINES PUBLISHED ANNUALLY BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

5. "HEALTH PLAN" MEANS AN ENTITY THAT CONTRACTS WITH THE ADMINISTRATION FOR SERVICES PROVIDED PURSUANT TO ARTICLE 1 OF THIS CHAPTER.

6. "MEMBER" MEANS A PERSON WHO IS ELIGIBLE FOR AND ENROLLED IN THE PROGRAM, WHO IS UNDER NINETEEN YEARS OF AGE AND WHOSE GROSS HOUSEHOLD INCOME MEETS THE FOLLOWING REQUIREMENTS:

(a) BEGINNING ON NOVEMBER 1, 1998 THROUGH SEPTEMBER 30, 1999, HAS INCOME AT OR BELOW ONE HUNDRED FIFTY PER CENT OF THE FEDERAL POVERTY LEVEL.

(b) BEGINNING ON OCTOBER 1, 1999 AND FOR EACH FISCAL YEAR THEREAFTER, HAS INCOME AT OR BELOW TWO HUNDRED PER CENT OF THE FEDERAL POVERTY LEVEL.

7. "NONCONTRACTING PROVIDER" MEANS AN ENTITY THAT PROVIDES HOSPITAL OR MEDICAL CARE BUT DOES NOT HAVE A CONTRACT OR SUBCONTRACT WITH THE ADMINISTRATION.

8. "PHYSICIAN" MEANS A PERSON LICENSED PURSUANT TO TITLE 32, CHAPTER 13 OR 17.

9. "PREPAID CAPITATED" MEANS A METHOD OF PAYMENT BY WHICH A CONTRACTOR DELIVERS HEALTH CARE SERVICES FOR THE DURATION OF A CONTRACT TO A SPECIFIED NUMBER OF MEMBERS BASED ON A FIXED RATE PER MEMBER, PER MONTH WITHOUT REGARD TO THE NUMBER OF MEMBERS WHO RECEIVE CARE OR THE AMOUNT OF HEALTH CARE SERVICES PROVIDED TO A MEMBER.

10. "PRIMARY CARE PHYSICIAN" MEANS A PHYSICIAN WHO IS A FAMILY PRACTITIONER, GENERAL PRACTITIONER, PEDIATRICIAN, GENERAL INTERNIST, OBSTETRICIAN OR GYNECOLOGIST.

11. "PRIMARY CARE PRACTITIONER" MEANS A NURSE PRACTITIONER WHO IS CERTIFIED PURSUANT TO TITLE 32, CHAPTER 15 OR A PHYSICIAN ASSISTANT WHO IS LICENSED PURSUANT TO TITLE 32, CHAPTER 25 AND WHO IS ACTING WITHIN THE RESPECTIVE SCOPE OF PRACTICE OF THOSE CHAPTERS.

12. "PROGRAM" MEANS THE CHILDREN'S HEALTH INSURANCE PROGRAM.

13. "QUALIFYING PLAN" MEANS A CONTRACTOR THAT CONTRACTS WITH THE STATE PURSUANT TO SECTION 38-651 TO PROVIDE HEALTH AND ACCIDENT INSURANCE FOR STATE EMPLOYEES AND THAT PROVIDES SERVICES TO MEMBERS PURSUANT TO SECTION 36-2989, SUBSECTION A.

14. "SPECIAL HEALTH CARE DISTRICT" MEANS A SPECIAL HEALTH CARE DISTRICT ORGANIZED PURSUANT TO TITLE 48, CHAPTER 31.

15. "TRIBAL FACILITY" MEANS A FACILITY THAT IS OPERATED BY AN INDIAN TRIBE AND THAT IS AUTHORIZED TO PROVIDE SERVICES PURSUANT TO PUBLIC LAW 93-638, AS AMENDED.

36-2982. Children's health insurance program; administration; nonentitlement; enrollment limitation; eligibility

A. THE CHILDREN'S HEALTH INSURANCE PROGRAM IS ESTABLISHED FOR CHILDREN WHO ARE ELIGIBLE PURSUANT TO SECTION 36-2981, PARAGRAPH 6. THE ADMINISTRATION SHALL ADMINISTER THE PROGRAM. ALL COVERED SERVICES SHALL BE PROVIDED BY HEALTH PLANS THAT HAVE CONTRACTS WITH THE ADMINISTRATION PURSUANT TO SECTION 36-2906, BY A QUALIFYING PLAN OR BY EITHER TRIBAL FACILITIES OR THE INDIAN HEALTH SERVICE FOR NATIVE AMERICANS WHO ARE ELIGIBLE FOR THE PROGRAM AND WHO ELECT TO RECEIVE SERVICES THROUGH THE INDIAN HEALTH SERVICE OR A TRIBAL FACILITY.

B. THIS ARTICLE DOES NOT CREATE A LEGAL ENTITLEMENT FOR ANY APPLICANT OR MEMBER WHO IS ELIGIBLE FOR THE PROGRAM. TOTAL ENROLLMENT IS LIMITED BASED ON THE ANNUAL APPROPRIATIONS MADE BY THE LEGISLATURE AND THE ENROLLMENT CAP PRESCRIBED IN SECTION 36-2985.

C. THE DIRECTOR SHALL TAKE ALL STEPS NECESSARY TO IMPLEMENT THE ADMINISTRATIVE STRUCTURE FOR THE PROGRAM AND TO BEGIN DELIVERING SERVICES TO PERSONS WITHIN SIXTY DAYS AFTER APPROVAL OF THE STATE PLAN BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

D. THE ADMINISTRATION SHALL PERFORM ELIGIBILITY DETERMINATIONS FOR PERSONS APPLYING FOR ELIGIBILITY AND ANNUAL REDETERMINATIONS FOR CONTINUED ELIGIBILITY PURSUANT TO THIS ARTICLE.

E. THE ADMINISTRATION SHALL ADOPT RULES FOR THE COLLECTION OF COPAYMENTS FROM MEMBERS WHOSE INCOME DOES NOT EXCEED ONE HUNDRED FIFTY PER CENT OF THE FEDERAL POVERTY LEVEL AND FOR THE COLLECTION OF COPAYMENTS AND PREMIUMS FROM MEMBERS WHOSE INCOME EXCEEDS ONE HUNDRED FIFTY PER CENT OF THE FEDERAL POVERTY LEVEL. THE DIRECTOR SHALL ADOPT RULES FOR DISENROLLING A MEMBER IF THE MEMBER DOES NOT PAY THE PREMIUM REQUIRED PURSUANT TO THIS SECTION. THE DIRECTOR SHALL ADOPT RULES TO PRESCRIBE THE CIRCUMSTANCES UNDER

WHICH THE ADMINISTRATION SHALL GRANT A HARDSHIP EXEMPTION TO THE DISENROLLMENT REQUIREMENTS OF THIS SUBSECTION FOR A MEMBER WHO IS NO LONGER ABLE TO PAY THE PREMIUM.

F. BEFORE ENROLLMENT, A MEMBER, OR IF THE MEMBER IS A MINOR, THAT MEMBER'S PARENT OR LEGAL GUARDIAN, SHALL SELECT AN AVAILABLE HEALTH PLAN IN THE MEMBER'S GEOGRAPHIC SERVICE AREA OR A QUALIFYING HEALTH PLAN OFFERED IN THE COUNTY, AND MAY SELECT A PRIMARY CARE PHYSICIAN OR PRIMARY CARE PRACTITIONER FROM AMONG THE AVAILABLE PHYSICIANS AND PRACTITIONERS PARTICIPATING WITH THE CONTRACTOR IN WHICH THE MEMBER IS ENROLLED. THE CONTRACTORS SHALL ONLY REIMBURSE COSTS OF SERVICES OR RELATED SERVICES PROVIDED BY OR UNDER REFERRAL FROM A PRIMARY CARE PHYSICIAN OR PRIMARY CARE PRACTITIONER PARTICIPATING IN THE CONTRACT IN WHICH THE MEMBER IS ENROLLED, EXCEPT FOR EMERGENCY SERVICES THAT SHALL BE REIMBURSED PURSUANT TO SECTION 36-2987. THE DIRECTOR SHALL ESTABLISH REQUIREMENTS AS TO THE MINIMUM TIME PERIOD THAT A MEMBER IS ASSIGNED TO SPECIFIC CONTRACTORS.

G. ELIGIBILITY FOR THE PROGRAM IS CREDITABLE COVERAGE AS DEFINED IN SECTION 20-1379.

H. ON APPLICATION FOR ELIGIBILITY FOR THE PROGRAM, THE MEMBER, OR IF THE MEMBER IS A MINOR, THE MEMBER'S PARENT OR GUARDIAN, SHALL RECEIVE AN APPLICATION FOR AND A PROGRAM DESCRIPTION OF THE PREMIUM SHARING PROGRAM.

I. NOTWITHSTANDING SECTION 36-2983, THE ADMINISTRATION MAY PURCHASE FOR A MEMBER EMPLOYER SPONSORED GROUP HEALTH INSURANCE WITH STATE AND FEDERAL MONIES AVAILABLE PURSUANT TO THIS ARTICLE, SUBJECT TO ANY RESTRICTIONS IMPOSED BY THE FEDERAL HEALTH CARE FINANCING ADMINISTRATION. THIS SUBSECTION DOES NOT APPLY TO MEMBERS WHO ARE ELIGIBLE FOR HEALTH BENEFITS COVERAGE UNDER A STATE HEALTH BENEFITS PLAN BASED ON A FAMILY MEMBER'S EMPLOYMENT WITH A PUBLIC AGENCY IN THIS STATE.

36-2983. Eligibility for the program

A. THE ADMINISTRATION SHALL ESTABLISH A STREAMLINED ELIGIBILITY PROCESS FOR APPLICANTS TO THE PROGRAM AND SHALL ISSUE A CERTIFICATE OF ELIGIBILITY AT THE TIME ELIGIBILITY FOR THE PROGRAM IS DETERMINED. ELIGIBILITY SHALL BE BASED ON GROSS HOUSEHOLD INCOME FOR A MEMBER AS DEFINED IN SECTION 36-2981. THE ADMINISTRATION SHALL NOT APPLY A RESOURCE TEST IN THE ELIGIBILITY DETERMINATION OR REDETERMINATION PROCESS.

B. THE ADMINISTRATION SHALL USE A SIMPLIFIED ELIGIBILITY FORM THAT MAY BE MAILED TO THE ADMINISTRATION. ONCE A COMPLETED APPLICATION IS RECEIVED, INCLUDING ADEQUATE VERIFICATION OF INCOME, THE ADMINISTRATION SHALL EXPEDITE THE ELIGIBILITY DETERMINATION AND ENROLLMENT ON A PROSPECTIVE BASIS.

C. THE DATE OF ELIGIBILITY IS THE FIRST DAY OF THE MONTH FOLLOWING A DETERMINATION OF ELIGIBILITY IF THE DECISION IS MADE BY THE TWENTY-FIFTH DAY OF THE MONTH. A PERSON WHO IS DETERMINED ELIGIBLE FOR THE PROGRAM AFTER THE TWENTY-FIFTH DAY OF THE MONTH IS ELIGIBLE FOR THE PROGRAM THE FIRST DAY OF THE SECOND MONTH FOLLOWING THE DETERMINATION OF ELIGIBILITY.

D. AN APPLICANT FOR THE PROGRAM WHO APPEARS TO BE ELIGIBLE PURSUANT TO SECTION 36-2901, PARAGRAPH 6, SUBDIVISION (a) SHALL HAVE A SOCIAL SECURITY

NUMBER OR SHALL APPLY FOR A SOCIAL SECURITY NUMBER WITHIN THIRTY DAYS AFTER THE APPLICANT SUBMITS AN APPLICATION FOR THE PROGRAM.

E. IN ORDER TO BE ELIGIBLE FOR THE PROGRAM, A PERSON SHALL BE A RESIDENT OF THIS STATE AND SHALL MEET TITLE XIX REQUIREMENTS FOR UNITED STATES CITIZENSHIP OR QUALIFIED ALIEN STATUS IN THE MANNER PRESCRIBED IN SECTION 36-2903.03.

F. IN DETERMINING THE ELIGIBILITY FOR ALL QUALIFIED ALIENS PURSUANT TO THIS ARTICLE, THE INCOME AND RESOURCES OF A PERSON WHO EXECUTED AN AFFIDAVIT OF SUPPORT PURSUANT TO SECTION 213A OF THE IMMIGRATION AND NATIONALITY ACT ON BEHALF OF THE QUALIFIED ALIEN AND THE INCOME AND RESOURCES OF THE SPOUSE, IF ANY, OF THE SPONSORING INDIVIDUAL SHALL BE COUNTED AT THE TIME OF APPLICATION AND FOR THE REDETERMINATION OF ELIGIBILITY FOR THE DURATION OF THE ATTRIBUTION PERIOD AS SPECIFIED IN FEDERAL LAW.

G. PURSUANT TO FEDERAL LAW, A PERSON IS NOT ELIGIBLE FOR THE PROGRAM IF THAT PERSON IS:

1. ELIGIBLE FOR TITLE XIX OR OTHER FEDERALLY OPERATED OR FINANCED HEALTH CARE INSURANCE PROGRAMS, EXCEPT THE INDIAN HEALTH SERVICE.

2. COVERED BY ANY GROUP HEALTH PLAN OR OTHER HEALTH INSURANCE COVERAGE AS DEFINED IN SECTION 2791 OF THE PUBLIC HEALTH SERVICE ACT. GROUP HEALTH PLAN OR OTHER HEALTH INSURANCE COVERAGE DOES NOT INCLUDE COVERAGE TO PERSONS WHO ARE DEFINED AS ELIGIBLE PURSUANT TO THE PREMIUM SHARING PROGRAM.

3. A MEMBER OF A FAMILY THAT IS ELIGIBLE FOR HEALTH BENEFITS COVERAGE UNDER A STATE HEALTH BENEFIT PLAN BASED ON A FAMILY MEMBER'S EMPLOYMENT WITH A PUBLIC AGENCY IN THIS STATE.

4. AN INMATE OF A PUBLIC INSTITUTION OR A PATIENT IN AN INSTITUTION FOR MENTAL DISEASES. THIS PARAGRAPH DOES NOT APPLY TO SERVICES FURNISHED IN A STATE OPERATED MENTAL HOSPITAL OR TO RESIDENTIAL OR OTHER TWENTY-FOUR HOUR THERAPEUTICALLY PLANNED STRUCTURED SERVICES.

H. A CHILD WHO IS COVERED UNDER AN EMPLOYER'S GROUP HEALTH INSURANCE PLAN OR THROUGH FAMILY OR INDIVIDUAL HEALTH CARE COVERAGE SHALL NOT BE ENROLLED IN THE PROGRAM. IF THE HEALTH INSURANCE COVERAGE IS VOLUNTARILY DISCONTINUED FOR ANY REASON, EXCEPT FOR THE LOSS OF HEALTH INSURANCE DUE TO LOSS OF EMPLOYMENT OR OTHER INVOLUNTARY REASON, THE CHILD IS NOT ELIGIBLE FOR THE PROGRAM FOR A PERIOD OF THREE MONTHS FROM THE DATE THAT THE HEALTH CARE COVERAGE WAS DISCONTINUED. THE ADMINISTRATION MAY WAIVE THE THREE MONTH PERIOD FOR ANY CHILD WHO IS SERIOUSLY OR CHRONICALLY ILL. FOR THE PURPOSES OF THE WAIVER, "CHRONICALLY ILL" MEANS A MEDICAL CONDITION THAT REQUIRES FREQUENT AND ONGOING TREATMENT AND THAT IF NOT PROPERLY TREATED WILL SERIOUSLY AFFECT THE CHILD'S OVERALL HEALTH. THE ADMINISTRATION SHALL ESTABLISH RULES TO FURTHER DEFINE CONDITIONS THAT CONSTITUTE A SERIOUS OR CHRONIC ILLNESS.

I. PURSUANT TO FEDERAL LAW, A PRIVATE INSURER, AS DEFINED BY THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, SHALL NOT LIMIT ENROLLMENT BY CONTRACT OR ANY OTHER MEANS BASED ON THE PRESUMPTION THAT A CHILD MAY BE ELIGIBLE FOR THE PROGRAM.

36-2985. Enrollment cap; program termination; spending limitation

A. IF THE DIRECTOR DETERMINES THAT MONIES MAY BE INSUFFICIENT FOR THE PROGRAM THE DIRECTOR SHALL IMMEDIATELY NOTIFY THE GOVERNOR, THE PRESIDENT OF THE SENATE AND THE SPEAKER OF THE HOUSE OF REPRESENTATIVES. AFTER CONSULTING WITH THE GOVERNOR, THE ADMINISTRATION SHALL STOP PROCESSING NEW APPLICATIONS FOR THE PROGRAM UNTIL THE ADMINISTRATION IS ABLE TO VERIFY THAT FUNDING IS SUFFICIENT TO BEGIN PROCESSING APPLICATIONS AND THE GOVERNOR AGREES THAT THE ADMINISTRATION MAY BEGIN PROCESSING APPLICATIONS.

B. IF THE FEDERAL GOVERNMENT ELIMINATES FEDERAL FUNDING FOR THE PROGRAM OR SIGNIFICANTLY REDUCES THE FEDERAL FUNDING BELOW THE ESTIMATED FEDERAL EXPENDITURES, THE ADMINISTRATION SHALL IMMEDIATELY STOP PROCESSING ALL APPLICATIONS AND SHALL PROVIDE AT LEAST THIRTY DAYS' ADVANCE NOTICE TO CONTRACTORS AND MEMBERS THAT THE PROGRAM WILL TERMINATE.

C. THE TOTAL AMOUNT OF STATE MONIES THAT MAY BE SPENT IN ANY FISCAL YEAR BY THE ADMINISTRATION FOR HEALTH CARE PROVIDED UNDER THIS ARTICLE SHALL NOT EXCEED THE AMOUNT APPROPRIATED OR AUTHORIZED BY SECTION 35-173.

D. THIS ARTICLE DOES NOT IMPOSE A DUTY ON AN OFFICER, AGENT OR EMPLOYEE OF THIS STATE TO DISCHARGE A RESPONSIBILITY OR TO CREATE ANY RIGHT IN A PERSON OR GROUP IF THE DISCHARGE OR RIGHT WOULD REQUIRE AN EXPENDITURE OF STATE MONIES IN EXCESS OF THE EXPENDITURE AUTHORIZED BY LEGISLATIVE APPROPRIATION FOR THAT SPECIFIC PURPOSE.

36-2986. Administration; powers and duties of director

A. THE DIRECTOR HAS FULL OPERATIONAL AUTHORITY TO ADOPT RULES OR TO USE THE APPROPRIATE RULES ADOPTED FOR ARTICLE 1 OF THIS CHAPTER TO IMPLEMENT THIS ARTICLE, INCLUDING ANY OF THE FOLLOWING:

1. CONTRACT ADMINISTRATION AND OVERSIGHT OF CONTRACTORS.

2. DEVELOPMENT OF A COMPLETE SYSTEM OF ACCOUNTS AND CONTROLS FOR THE PROGRAM INCLUDING PROVISIONS DESIGNED TO ENSURE THAT COVERED HEALTH AND MEDICAL SERVICES PROVIDED THROUGH THE SYSTEM ARE NOT USED UNNECESSARILY OR UNREASONABLY INCLUDING INPATIENT BEHAVIORAL HEALTH SERVICES PROVIDED IN A HOSPITAL.

3. ESTABLISHMENT OF PEER REVIEW AND UTILIZATION REVIEW FUNCTIONS FOR ALL CONTRACTORS.

4. DEVELOPMENT AND MANAGEMENT OF A CONTRACTOR PAYMENT SYSTEM.

5. ESTABLISHMENT AND MANAGEMENT OF A COMPREHENSIVE SYSTEM FOR ASSURING QUALITY OF CARE.

6. ESTABLISHMENT AND MANAGEMENT OF A SYSTEM TO PREVENT FRAUD BY MEMBERS, CONTRACTORS AND HEALTH CARE PROVIDERS.

7. DEVELOPMENT OF AN OUTREACH PROGRAM. THE ADMINISTRATION SHALL COORDINATE WITH PUBLIC AND PRIVATE ENTITIES TO PROVIDE OUTREACH SERVICES FOR CHILDREN UNDER THIS ARTICLE. PRIORITY SHALL BE GIVEN TO THOSE FAMILIES WHO ARE MOVING OFF WELFARE. OUTREACH ACTIVITIES SHALL INCLUDE STRATEGIES TO INFORM COMMUNITIES, INCLUDING TRIBAL COMMUNITIES, ABOUT THE PROGRAM, ENSURE A

WIDE DISTRIBUTION OF APPLICATIONS AND PROVIDE TRAINING FOR OTHER ENTITIES TO ASSIST WITH THE APPLICATION PROCESS.

8. COORDINATION OF BENEFITS PROVIDED UNDER THIS ARTICLE FOR ANY MEMBER. THE DIRECTOR MAY REQUIRE THAT CONTRACTORS AND NONCONTRACTING PROVIDERS ARE RESPONSIBLE FOR THE COORDINATION OF BENEFITS FOR SERVICES PROVIDED UNDER THIS ARTICLE. REQUIREMENTS FOR COORDINATION OF BENEFITS BY NONCONTRACTING PROVIDERS UNDER THIS SECTION ARE LIMITED TO COORDINATION WITH STANDARD HEALTH INSURANCE AND DISABILITY INSURANCE POLICIES AND SIMILAR PROGRAMS FOR HEALTH COVERAGE. THE DIRECTOR MAY REQUIRE MEMBERS TO ASSIGN TO THE ADMINISTRATION RIGHTS TO ALL TYPES OF MEDICAL BENEFITS TO WHICH THE PERSON IS ENTITLED, INCLUDING FIRST PARTY MEDICAL BENEFITS UNDER AUTOMOBILE INSURANCE POLICIES. THE STATE HAS A RIGHT OF SUBROGATION AGAINST ANY OTHER PERSON OR FIRM TO ENFORCE THE ASSIGNMENT OF MEDICAL BENEFITS. THE PROVISIONS OF THIS PARAGRAPH ARE CONTROLLING OVER THE PROVISIONS OF ANY INSURANCE POLICY THAT PROVIDES BENEFITS TO A MEMBER IF THE POLICY IS INCONSISTENT WITH THIS PARAGRAPH.

9. DEVELOPMENT AND MANAGEMENT OF AN ELIGIBILITY, ENROLLMENT AND REDETERMINATION SYSTEM INCLUDING A PROCESS FOR QUALITY CONTROL.

10. ESTABLISHMENT AND MAINTENANCE OF AN ENCOUNTER CLAIMS SYSTEM THAT ENSURES THAT NINETY PER CENT OF THE CLEAN CLAIMS ARE PAID WITHIN THIRTY DAYS AFTER RECEIPT AND NINETY-NINE PER CENT OF THE REMAINING CLEAN CLAIMS ARE PAID WITHIN NINETY DAYS AFTER RECEIPT BY THE ADMINISTRATION OR CONTRACTOR UNLESS AN ALTERNATIVE PAYMENT SCHEDULE IS AGREED TO BY THE CONTRACTOR AND THE PROVIDER. FOR THE PURPOSES OF THIS PARAGRAPH, "CLEAN CLAIMS" HAS THE SAME MEANING PRESCRIBED IN SECTION 36-2904, SUBSECTION G.

11. ESTABLISHMENT OF STANDARDS FOR THE COORDINATION OF MEDICAL CARE AND MEMBER TRANSFERS.

12. REQUIRING CONTRACTORS TO SUBMIT ENCOUNTER DATA IN A FORM SPECIFIED BY THE DIRECTOR.

13. ASSESSING CIVIL PENALTIES FOR IMPROPER BILLING AS PRESCRIBED IN SECTION 36-2903.01, SUBSECTION L.

B. NOTWITHSTANDING ANY OTHER LAW, IF CONGRESS AMENDS TITLE XXI OF THE SOCIAL SECURITY ACT AND THE ADMINISTRATION IS REQUIRED TO MAKE CONFORMING CHANGES TO RULES ADOPTED PURSUANT TO THIS ARTICLE, THE ADMINISTRATION SHALL REQUEST A HEARING WITH THE JOINT HEALTH COMMITTEE OF REFERENCE FOR REVIEW OF THE PROPOSED RULE CHANGES.

C. THE DIRECTOR MAY SUBCONTRACT DISTINCT ADMINISTRATIVE FUNCTIONS TO ONE OR MORE PERSONS WHO MAY BE CONTRACTORS WITHIN THE SYSTEM.

D. THE DIRECTOR SHALL REQUIRE AS A CONDITION OF A CONTRACT WITH ANY CONTRACTOR THAT ALL RECORDS RELATING TO CONTRACT COMPLIANCE ARE AVAILABLE FOR INSPECTION BY THE ADMINISTRATION AND THAT THESE RECORDS BE MAINTAINED BY THE CONTRACTOR FOR FIVE YEARS. THE DIRECTOR SHALL ALSO REQUIRE THAT THESE RECORDS ARE AVAILABLE BY A CONTRACTOR ON REQUEST OF THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

E. SUBJECT TO EXISTING LAW RELATING TO PRIVILEGE AND PROTECTION, THE DIRECTOR SHALL PRESCRIBE BY RULE THE TYPES OF INFORMATION THAT ARE CONFIDENTIAL AND CIRCUMSTANCES UNDER WHICH THIS INFORMATION MAY BE USED OR RELEASED, INCLUDING REQUIREMENTS FOR PHYSICIAN-PATIENT CONFIDENTIALITY. NOTWITHSTANDING ANY OTHER LAW, THESE RULES SHALL BE DESIGNED TO PROVIDE FOR THE EXCHANGE OF NECESSARY INFORMATION FOR THE PURPOSES OF ELIGIBILITY DETERMINATION UNDER THIS ARTICLE. NOTWITHSTANDING ANY OTHER LAW, A MEMBER'S MEDICAL RECORD SHALL BE RELEASED WITHOUT THE MEMBER'S CONSENT IN SITUATIONS OF SUSPECTED CASES OF FRAUD OR ABUSE RELATING TO THE SYSTEM TO AN OFFICER OF THIS STATE'S CERTIFIED ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM FRAUD CONTROL UNIT WHO HAS SUBMITTED A WRITTEN REQUEST FOR THE MEDICAL RECORD.

F. THE DIRECTOR SHALL PROVIDE FOR THE TRANSITION OF MEMBERS BETWEEN CONTRACTORS AND NONCONTRACTING PROVIDERS AND THE TRANSFER OF MEMBERS WHO HAVE BEEN DETERMINED ELIGIBLE FROM HOSPITALS THAT DO NOT HAVE CONTRACTS TO CARE FOR THESE PERSONS.

G. TO THE EXTENT THAT SERVICES ARE FURNISHED PURSUANT TO THIS ARTICLE A CONTRACTOR IS NOT SUBJECT TO TITLE 20 UNLESS THE CONTRACTOR IS A QUALIFYING PLAN AND HAS ELECTED TO PROVIDE SERVICES PURSUANT TO THIS ARTICLE.

H. AS A CONDITION OF A CONTRACT, THE DIRECTOR SHALL REQUIRE CONTRACT TERMS THAT ARE NECESSARY TO ENSURE ADEQUATE PERFORMANCE BY THE CONTRACTOR. CONTRACT PROVISIONS REQUIRED BY THE DIRECTOR INCLUDE THE MAINTENANCE OF DEPOSITS, PERFORMANCE BONDS, FINANCIAL RESERVES OR OTHER FINANCIAL SECURITY. THE DIRECTOR MAY WAIVE REQUIREMENTS FOR THE POSTING OF BONDS OR SECURITY FOR CONTRACTORS WHO HAVE POSTED OTHER SECURITY, EQUAL TO OR GREATER THAN THAT REQUIRED BY THE ADMINISTRATION, WITH A STATE AGENCY FOR THE PERFORMANCE OF HEALTH SERVICE CONTRACTS IF MONIES WOULD BE AVAILABLE FROM THAT SECURITY FOR THE SYSTEM ON DEFAULT BY THE CONTRACTOR.

I. THE DIRECTOR SHALL ESTABLISH SOLVENCY REQUIREMENTS IN CONTRACT THAT MAY INCLUDE WITHHOLDING OR FORFEITURE OF PAYMENTS TO BE MADE TO A CONTRACTOR BY THE ADMINISTRATION FOR THE FAILURE OF THE CONTRACTOR TO COMPLY WITH A PROVISION OF THE CONTRACT WITH THE ADMINISTRATION. THE DIRECTOR MAY ALSO REQUIRE CONTRACT TERMS ALLOWING THE ADMINISTRATION TO OPERATE A CONTRACTOR DIRECTLY UNDER CIRCUMSTANCES SPECIFIED IN THE CONTRACT. THE ADMINISTRATION SHALL OPERATE THE CONTRACTOR ONLY AS LONG AS IT IS NECESSARY TO ASSURE DELIVERY OF UNINTERRUPTED CARE TO MEMBERS ENROLLED WITH THE CONTRACTOR AND TO ACCOMPLISH THE ORDERLY TRANSITION OF MEMBERS TO OTHER CONTRACTORS OR UNTIL THE CONTRACTOR REORGANIZES OR OTHERWISE CORRECTS THE CONTRACT PERFORMANCE FAILURE. THE ADMINISTRATION SHALL NOT OPERATE A CONTRACTOR UNLESS, BEFORE THAT ACTION, THE ADMINISTRATION DELIVERS NOTICE TO THE CONTRACTOR PROVIDING AN OPPORTUNITY FOR A HEARING IN ACCORDANCE WITH PROCEDURES ESTABLISHED BY THE DIRECTOR. NOTWITHSTANDING THE PROVISIONS OF A CONTRACT, IF THE ADMINISTRATION FINDS THAT THE PUBLIC HEALTH, SAFETY OR WELFARE REQUIRES EMERGENCY ACTION, IT MAY OPERATE AS THE CONTRACTOR ON NOTICE TO THE CONTRACTOR AND PENDING AN ADMINISTRATIVE HEARING, WHICH IT SHALL PROMPTLY INSTITUTE.

J. FOR THE SOLE PURPOSE OF MATTERS CONCERNING AND DIRECTLY RELATED TO THIS ARTICLE, THE ADMINISTRATION IS EXEMPT FROM SECTION 41-192.

K. THE DIRECTOR MAY WITHHOLD PAYMENTS TO A NONCONTRACTING PROVIDER IF THE NONCONTRACTING PROVIDER DOES NOT COMPLY WITH THIS ARTICLE OR ADOPTED RULES THAT RELATE TO THE SPECIFIC SERVICES RENDERED AND BILLED TO THE ADMINISTRATION.

L. THE DIRECTOR SHALL:

1. PRESCRIBE UNIFORM FORMS TO BE USED BY ALL CONTRACTORS AND FURNISH UNIFORM FORMS AND PROCEDURES, INCLUDING METHODS OF IDENTIFICATION OF MEMBERS. THE RULES SHALL INCLUDE REQUIREMENTS THAT AN APPLICANT PERSONALLY COMPLETE OR ASSIST IN THE COMPLETION OF ELIGIBILITY APPLICATION FORMS, EXCEPT IN SITUATIONS IN WHICH THE PERSON IS DISABLED.

2. BY RULE, ESTABLISH A GRIEVANCE AND APPEAL PROCEDURE THAT CONFORMS WITH THE PROCESS AND THE TIME FRAMES SPECIFIED IN ARTICLE 1 OF THIS CHAPTER. IF THE PROGRAM IS SUSPENDED OR TERMINATED PURSUANT TO SECTION 36-2985, AN APPLICANT OR MEMBER IS NOT ENTITLED TO CONTEST THE DENIAL, SUSPENSION OR TERMINATION OF ELIGIBILITY FOR THE PROGRAM.

3. APPLY FOR AND ACCEPT FEDERAL MONIES AVAILABLE UNDER TITLE XXI OF THE SOCIAL SECURITY ACT. AVAILABLE STATE MONIES APPROPRIATED TO THE ADMINISTRATION FOR THE OPERATION OF THE PROGRAM SHALL BE USED AS MATCHING MONIES TO SECURE FEDERAL MONIES PURSUANT TO THIS SUBSECTION.

M. THE ADMINISTRATION IS ENTITLED TO ALL RIGHTS PROVIDED TO THE ADMINISTRATION FOR LIENS AND RELEASE OF CLAIMS AS SPECIFIED IN SECTIONS 36-2915 AND 36-2916 AND SHALL COORDINATE BENEFITS PURSUANT TO SECTION 36-2903, SUBSECTION F AND BE A PAYOR OF LAST RESORT FOR PERSONS WHO ARE ELIGIBLE PURSUANT TO THIS ARTICLE.

N. THE DIRECTOR SHALL FOLLOW THE SAME PROCEDURES FOR REVIEW COMMITTEES, IMMUNITY AND CONFIDENTIALITY THAT ARE PRESCRIBED IN ARTICLE 1 OF THIS CHAPTER.

36-2987. Reimbursement for the program

A. FOR INPATIENT HOSPITAL SERVICES, THE ADMINISTRATION SHALL REIMBURSE THE INDIAN HEALTH SERVICE OR A TRIBAL FACILITY BASED ON THE REIMBURSEMENT RATES FOR THE INDIAN HEALTH SERVICE AS PUBLISHED ANNUALLY IN THE FEDERAL REGISTER. FOR OUTPATIENT SERVICES, THE ADMINISTRATION SHALL REIMBURSE THE INDIAN HEALTH SERVICE OR A TRIBAL FACILITY BASED ON THE CAPPED FEE-FOR-SERVICE SCHEDULE ESTABLISHED BY THE DIRECTOR. IF CONGRESS AUTHORIZES ONE HUNDRED PER CENT PASS-THROUGH OF TITLE XXI MONIES FOR SERVICES PROVIDED IN AN INDIAN HEALTH SERVICE FACILITY OR A TRIBAL FACILITY, THE ADMINISTRATION SHALL REIMBURSE THE INDIAN HEALTH SERVICE OR THE TRIBAL FACILITY WITH THIS ENHANCED FEDERAL FUNDING BASED ON THE REIMBURSEMENT RATES FOR THE INDIAN HEALTH SERVICE OR THE TRIBAL FACILITY AS PUBLISHED ANNUALLY IN THE FEDERAL REGISTER.

B. CONTRACTORS SHALL REIMBURSE INPATIENT AND OUTPATIENT SERVICES BASED ON THE REIMBURSEMENT METHODOLOGY ESTABLISHED IN SECTION 36-2904 OR THE HOSPITAL REIMBURSEMENT PILOT PROGRAM ESTABLISHED BY THIS STATE.

C. FOR SERVICES RENDERED ON AND AFTER OCTOBER 1, 1998, THE ADMINISTRATION AND THE CONTRACTORS SHALL PAY A HOSPITAL'S RATE ESTABLISHED ACCORDING TO THIS SECTION SUBJECT TO THE FOLLOWING:

1. IF THE HOSPITAL'S BILL IS PAID WITHIN THIRTY DAYS AFTER THE DATE THE BILL WAS RECEIVED, THE ADMINISTRATION SHALL PAY NINETY-NINE PER CENT OF THE RATE.

2. IF THE HOSPITAL'S BILL IS PAID AFTER THIRTY DAYS BUT WITHIN SIXTY DAYS AFTER THE DATE THE BILL WAS RECEIVED, THE ADMINISTRATION SHALL PAY ONE HUNDRED PER CENT OF THE RATE.

3. IF THE HOSPITAL'S BILL IS PAID ANY TIME AFTER SIXTY DAYS AFTER THE DATE THE BILL WAS RECEIVED, THE ADMINISTRATION SHALL PAY ONE HUNDRED PER CENT OF THE RATE PLUS A FEE OF ONE PER CENT A MONTH FOR EACH MONTH OR PORTION OF A MONTH FOLLOWING THE SIXTIETH DAY OF RECEIPT OF THE BILL UNTIL THE DATE OF PAYMENT.

D. THE ADMINISTRATION AND THE CONTRACTORS SHALL PAY CLAIMS PURSUANT TO THE METHODOLOGY, DEFINITIONS AND TIME FRAMES SPECIFIED FOR CLEAN CLAIMS IN SECTION 36-2904, SUBSECTION G.

E. THE DIRECTOR SHALL SPECIFY ENROLLMENT PROCEDURES INCLUDING NOTICE TO CONTRACTORS OF ENROLLMENT. THE ADMINISTRATION SHALL SPECIFY IN CONTRACT WHEN A PERSON WHO HAS BEEN DETERMINED ELIGIBLE WILL BE ENROLLED WITH A CONTRACTOR AND THE DATE ON WHICH THE CONTRACTOR WILL BE FINANCIALLY RESPONSIBLE FOR HEALTH AND MEDICAL SERVICES TO THE PERSON.

F. THE DIRECTOR SHALL MONITOR ANY THIRD PARTY PAYMENT COLLECTIONS COLLECTED BY CONTRACTORS AND NONCONTRACTING PROVIDERS ACCORDING TO THE SAME PROCEDURES SPECIFIED FOR TITLE XIX PURSUANT TO SECTION 36-2903.01, SUBSECTION K.

G. ON ORAL OR WRITTEN NOTICE FROM THE MEMBER, OR THE MEMBER'S PARENT OR LEGAL GUARDIAN, THAT THE MEMBER, PARENT OR LEGAL GUARDIAN BELIEVES A CLAIM SHOULD BE COVERED BY THE PROGRAM, A CONTRACTOR OR NONCONTRACTING PROVIDER SHALL NOT DO EITHER OF THE FOLLOWING UNLESS THE CONTRACTOR OR NONCONTRACTING PROVIDER HAS VERIFIED THROUGH THE ADMINISTRATION THAT THE PERSON IS INELIGIBLE FOR THE PROGRAM, HAS NOT YET BEEN DETERMINED ELIGIBLE OR, AT THE TIME SERVICES WERE RENDERED, WAS NOT ELIGIBLE OR ENROLLED IN THE PROGRAM:

1. CHARGE, SUBMIT A CLAIM TO OR DEMAND OR OTHERWISE COLLECT PAYMENT FROM A MEMBER OR PERSON WHO HAS BEEN DETERMINED ELIGIBLE.

2. REFER OR REPORT A MEMBER OR PERSON WHO HAS BEEN DETERMINED ELIGIBLE TO A COLLECTION AGENCY OR CREDIT REPORTING AGENCY FOR THE FAILURE OF THE MEMBER OR PERSON WHO HAS BEEN DETERMINED ELIGIBLE TO PAY CHARGES FOR COVERED SERVICES UNLESS SPECIFICALLY AUTHORIZED BY THIS ARTICLE OR RULES ADOPTED PURSUANT TO THIS ARTICLE.

H. THE ADMINISTRATION MAY CONDUCT POSTPAYMENT REVIEW OF ALL PAYMENTS MADE BY THE ADMINISTRATION AND MAY RECOUP ANY MONIES ERRONEOUSLY PAID. THE DIRECTOR MAY ADOPT RULES THAT SPECIFY PROCEDURES FOR CONDUCTING POSTPAYMENT REVIEW. CONTRACTORS MAY CONDUCT A POSTPAYMENT REVIEW OF ALL CLAIMS PAID TO PROVIDERS AND MAY RECOUP MONIES THAT ARE ERRONEOUSLY PAID.

I. THE DIRECTOR OR THE DIRECTOR'S DESIGNEE MAY EMPLOY AND SUPERVISE PERSONNEL NECESSARY TO ASSIST THE DIRECTOR IN PERFORMING THE FUNCTIONS OF THE PROGRAM.

36-2988. Delivery of services; health plans; requirements

A. TO THE EXTENT POSSIBLE, THE ADMINISTRATION SHALL USE CONTRACTORS THAT HAVE A CONTRACT WITH THE ADMINISTRATION PURSUANT TO ARTICLE 1 OF THIS CHAPTER OR QUALIFYING PLANS TO PROVIDE SERVICES TO MEMBERS WHO QUALIFY FOR THE PROGRAM.

B. THE ADMINISTRATION HAS FULL AUTHORITY TO AMEND EXISTING CONTRACTS AWARDED PURSUANT TO ARTICLE 1 OF THIS CHAPTER.

C. AS DETERMINED BY THE DIRECTOR, REINSURANCE MAY BE PROVIDED AGAINST EXPENSES IN EXCESS OF A SPECIFIED AMOUNT ON BEHALF OF ANY MEMBER FOR COVERED EMERGENCY SERVICES, INPATIENT SERVICES OR OUTPATIENT SERVICES IN THE SAME MANNER AS REINSURANCE PROVIDED UNDER ARTICLE 1 OF THIS CHAPTER. SUBJECT TO THE APPROVAL OF THE DIRECTOR, REINSURANCE MAY BE OBTAINED AGAINST EXPENSES IN EXCESS OF A SPECIFIED AMOUNT ON BEHALF OF ANY MEMBER.

D. NOTWITHSTANDING ANY OTHER LAW, THE ADMINISTRATION MAY PROCURE, PROVIDE OR COORDINATE COVERED SERVICES BY INTERAGENCY AGREEMENT WITH AUTHORIZED AGENCIES OF THIS STATE FOR DISTINCT GROUPS OF MEMBERS, INCLUDING PERSONS ELIGIBLE FOR CHILDREN'S REHABILITATIVE SERVICES THROUGH THE DEPARTMENT OF HEALTH SERVICES AND MEMBERS ELIGIBLE FOR COMPREHENSIVE MEDICAL AND DENTAL BENEFITS THROUGH THE DEPARTMENT OF ECONOMIC SECURITY.

E. AFTER CONTRACTS ARE AWARDED PURSUANT TO THIS SECTION, THE DIRECTOR MAY NEGOTIATE WITH ANY SUCCESSFUL BIDDER FOR THE EXPANSION OR CONTRACTION OF SERVICES OR SERVICE AREAS.

F. PAYMENTS TO CONTRACTORS SHALL BE MADE MONTHLY AND MAY BE SUBJECT TO CONTRACT PROVISIONS REQUIRING THE RETENTION OF A SPECIFIED PERCENTAGE OF THE PAYMENT BY THE DIRECTOR, A RESERVE FUND OR ANY OTHER CONTRACT PROVISIONS BY WHICH ADJUSTMENTS TO THE PAYMENTS ARE MADE BASED ON UTILIZATION EFFICIENCY, INCLUDING INCENTIVES FOR MAINTAINING QUALITY CARE AND MINIMIZING UNNECESSARY INPATIENT SERVICES. RESERVE MONIES WITHHELD FROM CONTRACTORS SHALL BE DISTRIBUTED TO PROVIDERS WHO MEET PERFORMANCE STANDARDS ESTABLISHED BY THE DIRECTOR. ANY RESERVE FUND ESTABLISHED PURSUANT TO THIS SUBSECTION SHALL BE ESTABLISHED AS A SEPARATE ACCOUNT WITHIN THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM.

G. THE DIRECTOR MAY NEGOTIATE AT ANY TIME WITH A HOSPITAL ON BEHALF OF A CONTRACTOR FOR INPATIENT HOSPITAL SERVICES AND OUTPATIENT HOSPITAL SERVICES PROVIDED PURSUANT TO THE REQUIREMENTS SPECIFIED IN SECTION 36-2904.

H. A CONTRACTOR MAY REQUIRE THAT SUBCONTRACTING PROVIDERS OR NONCONTRACTING PROVIDERS BE PAID FOR COVERED SERVICES, OTHER THAN HOSPITAL SERVICES, ACCORDING TO THE CAPPED FEE-FOR-SERVICE SCHEDULE ADOPTED BY THE ADMINISTRATION OR AT LOWER RATES AS MAY BE NEGOTIATED BY THE CONTRACTOR.

I. A SCHOOL DISTRICT MAY PERFORM OUTREACH AND INFORMATION ACTIVITIES THAT RELATE TO THIS ARTICLE, WITH PERMISSION OF THE SCHOOL PRINCIPAL AND SCHOOL DISTRICT. THE ADMINISTRATION AND CONTRACTORS MAY COLLABORATE WITH

ENTITIES SUCH AS COMMUNITY BASED ORGANIZATIONS, FAITH BASED ORGANIZATIONS, SCHOOLS AND SCHOOL DISTRICTS FOR OUTREACH AND INFORMATION ACTIVITIES RELATED TO THIS ARTICLE. OUTREACH AND INFORMATION ACTIVITIES SHALL NOT INCLUDE DELIVERY OF SERVICES, SCREENING ACTIVITIES, ELIGIBILITY DETERMINATION OR ENROLLMENT RELATED TO THIS ARTICLE. OUTREACH AND INFORMATION ACTIVITIES INCLUDE PROMOTION OF HEALTH CARE COVERAGE, PARTICIPATION IN SCHOOL EVENTS AND DISTRIBUTION OF APPLICATIONS AND MATERIALS TO PUPILS AND THEIR FAMILIES. OUTREACH AND INFORMATION ACTIVITIES PERFORMED BY THE ADMINISTRATION, CONTRACTORS OR A SCHOOL DISTRICT SHALL NOT REDUCE OR INTERFERE WITH CLASSROOM INSTRUCTION TIME.

J. THE ADMINISTRATION IS EXEMPT FROM THE PROCUREMENT CODE PURSUANT TO SECTION 41-2501.

36-2989. Covered health and medical services; modifications; related delivery of service requirements

A. EXCEPT AS PROVIDED IN THIS SECTION, BEGINNING ON OCTOBER 1, 2001, HEALTH AND MEDICAL SERVICES AS DEFINED IN SECTION 36-2907 ARE COVERED SERVICES AND INCLUDE:

1. INPATIENT HOSPITAL SERVICES THAT ARE ORDINARILY FURNISHED BY A HOSPITAL FOR THE CARE AND TREATMENT OF INPATIENTS, THAT ARE MEDICALLY NECESSARY AND THAT ARE PROVIDED UNDER THE DIRECTION OF A PHYSICIAN OR A PRIMARY CARE PRACTITIONER. FOR THE PURPOSES OF THIS PARAGRAPH, INPATIENT HOSPITAL SERVICES EXCLUDE SERVICES IN AN INSTITUTION FOR TUBERCULOSIS OR MENTAL DISEASES UNLESS AUTHORIZED BY FEDERAL LAW.

2. OUTPATIENT HEALTH SERVICES THAT ARE MEDICALLY NECESSARY AND ORDINARILY PROVIDED IN HOSPITALS, CLINICS, OFFICES AND OTHER HEALTH CARE FACILITIES BY LICENSED HEALTH CARE PROVIDERS. FOR THE PURPOSES OF THIS PARAGRAPH, "OUTPATIENT HEALTH SERVICES" INCLUDES SERVICES PROVIDED BY OR UNDER THE DIRECTION OF A PHYSICIAN OR A PRIMARY CARE PRACTITIONER.

3. OTHER LABORATORY AND X-RAY SERVICES ORDERED BY A PHYSICIAN OR A PRIMARY CARE PRACTITIONER.

4. MEDICATIONS THAT ARE MEDICALLY NECESSARY AND ORDERED ON PRESCRIPTION BY A PHYSICIAN, A PRIMARY CARE PRACTITIONER OR A DENTIST LICENSED PURSUANT TO TITLE 32, CHAPTER 11.

5. MEDICAL SUPPLIES, EQUIPMENT AND PROSTHETIC DEVICES.

6. TREATMENT OF MEDICAL CONDITIONS OF THE EYE INCLUDING EYE EXAMINATIONS FOR PRESCRIPTIVE LENSES AND THE PROVISION OF PRESCRIPTIVE LENSES FOR MEMBERS.

7. MEDICALLY NECESSARY DENTAL SERVICES.

8. WELL CHILD SERVICES, IMMUNIZATIONS AND PREVENTION SERVICES.

9. FAMILY PLANNING SERVICES THAT DO NOT INCLUDE ABORTION OR ABORTION COUNSELING. IF A CONTRACTOR ELECTS NOT TO PROVIDE FAMILY PLANNING SERVICES, THIS ELECTION DOES NOT DISQUALIFY THE CONTRACTOR FROM DELIVERING ALL OTHER COVERED HEALTH AND MEDICAL SERVICES UNDER THIS ARTICLE. IN THAT EVENT, THE ADMINISTRATION MAY CONTRACT DIRECTLY WITH ANOTHER CONTRACTOR, INCLUDING AN OUTPATIENT SURGICAL CENTER OR A NONCONTRACTING PROVIDER, TO DELIVER FAMILY

PLANNING SERVICES TO A MEMBER WHO IS ENROLLED WITH A CONTRACTOR WHO ELECTS NOT TO PROVIDE FAMILY PLANNING SERVICES.

10. PODIATRY SERVICES THAT ARE PERFORMED BY A PODIATRIST LICENSED PURSUANT TO TITLE 32, CHAPTER 7 AND THAT ARE ORDERED BY A PRIMARY CARE PHYSICIAN OR PRIMARY CARE PRACTITIONER.

11. MEDICALLY NECESSARY PANCREAS, HEART, LIVER, KIDNEY, CORNEA, LUNG AND HEART-LUNG TRANSPLANTS AND AUTOLOGOUS AND ALLOGENEIC BONE MARROW TRANSPLANTS AND IMMUNOSUPPRESSANT MEDICATIONS FOR THESE TRANSPLANTS ORDERED ON PRESCRIPTION BY A PHYSICIAN LICENSED PURSUANT TO TITLE 32, CHAPTER 13 OR 17.

12. MEDICALLY NECESSARY EMERGENCY AND NONEMERGENCY TRANSPORTATION.

13. INPATIENT AND OUTPATIENT BEHAVIORAL HEALTH SERVICES THAT ARE THE SAME AS THE LEAST RESTRICTIVE HEALTH BENEFITS COVERAGE PLAN FOR BEHAVIORAL HEALTH SERVICES THAT ARE OFFERED THROUGH A HEALTH CARE SERVICES ORGANIZATION FOR STATE EMPLOYEES UNDER SECTION 38-651.

B. THE ADMINISTRATION SHALL PAY NONCONTRACTING PROVIDERS ONLY FOR HEALTH AND MEDICAL SERVICES AS PRESCRIBED IN SUBSECTION A OF THIS SECTION.

C. TO THE EXTENT POSSIBLE AND PRACTICABLE, THE ADMINISTRATION AND CONTRACTORS SHALL PROVIDE FOR THE PRIOR APPROVAL OF MEDICALLY NECESSARY SERVICES PROVIDED PURSUANT TO THIS ARTICLE.

D. THE DIRECTOR SHALL MAKE AVAILABLE HOME HEALTH SERVICES IN LIEU OF HOSPITALIZATION PURSUANT TO CONTRACTS AWARDED UNDER THIS ARTICLE.

E. BEHAVIORAL HEALTH SERVICES SHALL BE PROVIDED TO MEMBERS THROUGH THE ADMINISTRATION'S INTERGOVERNMENTAL AGREEMENT WITH THE DIVISION OF BEHAVIORAL HEALTH IN THE DEPARTMENT OF HEALTH SERVICES. THE DIVISION OF BEHAVIORAL HEALTH IN THE DEPARTMENT OF HEALTH SERVICES SHALL USE ITS ESTABLISHED DIAGNOSTIC AND EVALUATION PROGRAM FOR REFERRALS OF CHILDREN WHO ARE NOT ALREADY ENROLLED PURSUANT TO THIS ARTICLE AND WHO MAY BE IN NEED OF BEHAVIORAL HEALTH SERVICES. IN ADDITION TO AN EVALUATION, THE DIVISION OF BEHAVIORAL HEALTH SHALL ALSO IDENTIFY CHILDREN WHO MAY BE ELIGIBLE UNDER SECTION 36-2901, PARAGRAPH 6, SUBDIVISION (a) OR SECTION 36-2931, PARAGRAPH 5 AND SHALL REFER THE CHILDREN TO THE APPROPRIATE AGENCY RESPONSIBLE FOR MAKING THE FINAL ELIGIBILITY DETERMINATION.

F. THE DIRECTOR SHALL ADOPT RULES FOR THE PROVISION OF TRANSPORTATION SERVICES FOR MEMBERS. PRIOR AUTHORIZATION IS NOT REQUIRED FOR MEDICALLY NECESSARY AMBULANCE TRANSPORTATION SERVICES RENDERED TO MEMBERS INITIATED BY DIALING TELEPHONE NUMBER 911 OR OTHER DESIGNATED EMERGENCY RESPONSE SYSTEMS.

G. THE DIRECTOR MAY ADOPT RULES TO ALLOW THE ADMINISTRATION TO USE A SECOND OPINION PROCEDURE UNDER WHICH SURGERY MAY NOT BE ELIGIBLE FOR COVERAGE PURSUANT TO THIS ARTICLE WITHOUT DOCUMENTATION AS TO NEED BY AT LEAST TWO PHYSICIANS OR PRIMARY CARE PRACTITIONERS.

H. ALL HEALTH AND MEDICAL SERVICES PROVIDED UNDER THIS ARTICLE SHALL BE PROVIDED IN THE GEOGRAPHIC SERVICE AREA OF THE MEMBER, EXCEPT:

1. EMERGENCY SERVICES AND SPECIALTY SERVICES.

2. THE DIRECTOR MAY PERMIT THE DELIVERY OF HEALTH AND MEDICAL SERVICES IN OTHER THAN THE GEOGRAPHIC SERVICE AREA IN THIS STATE OR IN AN ADJOINING STATE IF IT IS DETERMINED THAT MEDICAL PRACTICE PATTERNS JUSTIFY THE DELIVERY OF SERVICES OR A NET REDUCTION IN TRANSPORTATION COSTS CAN REASONABLY BE EXPECTED. NOTWITHSTANDING SECTION 36-2981, PARAGRAPH 8 OR 11, IF SERVICES ARE PROCURED FROM A PHYSICIAN OR PRIMARY CARE PRACTITIONER IN AN ADJOINING STATE, THE PHYSICIAN OR PRIMARY CARE PRACTITIONER SHALL BE LICENSED TO PRACTICE IN THAT STATE PURSUANT TO LICENSING STATUTES IN THAT STATE THAT ARE SIMILAR TO TITLE 32, CHAPTER 13, 15, 17 OR 25.

I. COVERED OUTPATIENT SERVICES SHALL BE SUBCONTRACTED BY A PRIMARY CARE PHYSICIAN OR PRIMARY CARE PRACTITIONER TO OTHER LICENSED HEALTH CARE PROVIDERS TO THE EXTENT PRACTICABLE FOR PURPOSES OF MAKING HEALTH CARE SERVICES AVAILABLE TO UNDERSERVED AREAS, REDUCING COSTS OF PROVIDING MEDICAL CARE AND REDUCING TRANSPORTATION COSTS.

J. THE DIRECTOR SHALL ADOPT RULES THAT PRESCRIBE THE COORDINATION OF MEDICAL CARE FOR MEMBERS AND THAT INCLUDE A MECHANISM TO TRANSFER MEMBERS AND MEDICAL RECORDS AND INITIATE MEDICAL CARE.

K. THE DIRECTOR SHALL ADOPT RULES FOR THE REIMBURSEMENT OF SPECIALTY SERVICES PROVIDED TO THE MEMBER IF AUTHORIZED BY THE MEMBER'S PRIMARY CARE PHYSICIAN OR PRIMARY CARE PRACTITIONER.

36-2990. Quality of health care monitoring standard; development; adoption; use; additional monitoring; costs

A. THE ADMINISTRATION SHALL DEVELOP STANDARDS OF CARE THAT EACH CONTRACTOR SHALL USE TO MONITOR THE QUALITY OF HEALTH CARE RECEIVED BY MEMBERS.

B. THE DIRECTOR SHALL PERIODICALLY DETERMINE WHETHER EACH CONTRACTOR HAS PROPERLY ADOPTED AND IMPLEMENTED STANDARDS TO ENSURE THE QUALITY OF HEALTH CARE. IF THE DIRECTOR DETERMINES THAT A CONTRACTOR IS OUT OF COMPLIANCE, THE DIRECTOR SHALL UNDERTAKE ADDITIONAL EFFORTS TO MONITOR AND ASSESS THE QUALITY OF HEALTH CARE PROVIDED BY THAT CONTRACTOR FOR THE PERIOD OF TIME THAT THE DIRECTOR DEEMS NECESSARY. THE DIRECTOR SHALL DETERMINE THE COST INCURRED IN UNDERTAKING THESE SPECIAL EFFORTS AND SHALL DEDUCT THAT AMOUNT FROM ANY PAYMENT OWED TO THE CONTRACTOR.

36-2991. Fraud; penalties; enforcement; violation; classification

A. A PERSON SHALL NOT PROVIDE OR CAUSE TO BE PROVIDED FALSE OR FRAUDULENT INFORMATION ON AN APPLICATION FOR ELIGIBILITY PURSUANT TO THIS ARTICLE.

B. A PERSON WHO VIOLATES SUBSECTION A OF THIS SECTION, WHO IS DETERMINED ELIGIBLE FOR SERVICES PURSUANT TO THIS ARTICLE AND WHO WOULD HAVE BEEN DETERMINED INELIGIBLE IF THE PERSON HAD PROVIDED TRUE AND CORRECT INFORMATION IS SUBJECT, IN ADDITION TO ANY OTHER PENALTIES THAT MAY BE PRESCRIBED BY FEDERAL OR STATE LAW, TO A CIVIL PENALTY OF NOT MORE THAN THE AMOUNT INCURRED BY THE SYSTEM, INCLUDING CAPITATION PAYMENTS MADE ON BEHALF

OF THE PERSON. IN ADDITION, THE PERSON'S ELIGIBILITY MAY BE DISCONTINUED IN ACCORDANCE WITH RULES ADOPTED BY THE DIRECTOR.

C. IN ADDITION TO THE REQUIREMENTS OF STATE LAW, ANY APPLICABLE FRAUD AND ABUSE CONTROLS THAT ARE ENACTED UNDER FEDERAL LAW APPLY TO PERSONS WHO ARE ELIGIBLE FOR SERVICES UNDER THIS ARTICLE AND TO CONTRACTORS AND NONCONTRACTING PROVIDERS WHO PROVIDE SERVICES UNDER THIS ARTICLE.

D. THE DIRECTOR SHALL MAKE THE DETERMINATION TO ASSESS A CIVIL PENALTY AND IS RESPONSIBLE FOR COLLECTION OF THE PENALTY. THE DIRECTOR MAY ADOPT RULES THAT PRESCRIBE PROCEDURES FOR THE DETERMINATION AND COLLECTION OF CIVIL PENALTIES. THE DIRECTOR MAY COMPROMISE CIVIL PENALTIES IMPOSED UNDER THIS SECTION IN ACCORDANCE WITH CRITERIA ESTABLISHED IN RULES.

E. THE DIRECTOR SHALL ADOPT RULES PROVIDING FOR THE APPEAL OF A DECISION BY A PERSON ADVERSELY AFFECTED BY A DETERMINATION MADE BY THE DIRECTOR UNDER THIS SECTION. THE DIRECTOR'S FINAL DECISION IS SUBJECT TO JUDICIAL REVIEW PURSUANT TO TITLE 12, CHAPTER 7, ARTICLE 6.

F. AMOUNTS PAID BY THE STATE AND RECOVERED UNDER THIS SECTION SHALL BE DEPOSITED IN THE STATE GENERAL FUND, AND ANY APPLICABLE FEDERAL SHARE SHALL BE RETURNED TO THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

G. IF A CIVIL PENALTY IMPOSED PURSUANT TO SUBSECTION D OF THIS SECTION IS NOT PAID, THE STATE MAY FILE AN ACTION TO COLLECT THE CIVIL PENALTY IN THE SUPERIOR COURT IN MARICOPA COUNTY. MATTERS THAT WERE RAISED OR COULD HAVE BEEN RAISED IN A HEARING BEFORE THE DIRECTOR OR IN AN APPEAL PURSUANT TO TITLE 12, CHAPTER 7, ARTICLE 6 MAY NOT BE RAISED AS A DEFENSE TO THE CIVIL ACTION. AN ACTION BROUGHT PURSUANT TO THIS SUBSECTION SHALL BE INITIATED WITHIN SIX YEARS AFTER THE DATE THE CLAIM IS PRESENTED.

H. A PERSON WHO KNOWINGLY AIDS OR ABETS ANOTHER PERSON PURSUANT TO SECTION 13-301, 13-302 OR 13-303 IN THE COMMISSION OF AN OFFENSE UNDER THIS SECTION OR SECTION 13-3713 IS GUILTY OF A CLASS 5 FELONY.

36-2992. Duty to report fraud or abuse; immunity; unprofessional conduct

A. ALL CONTRACTORS AND NONCONTRACTING PROVIDERS SHALL ADVISE THE DIRECTOR OR THE DIRECTOR'S DESIGNEE IMMEDIATELY IN A WRITTEN REPORT OF ANY CASES OF SUSPECTED FRAUD OR ABUSE. THE DIRECTOR SHALL REVIEW THE REPORT AND CONDUCT A PRELIMINARY INVESTIGATION TO DETERMINE IF THERE IS A SUFFICIENT BASIS TO WARRANT A FULL INVESTIGATION. IF THE FINDINGS OF A PRELIMINARY INVESTIGATION GIVE THE DIRECTOR REASON TO BELIEVE THAT AN INCIDENT OF FRAUD OR ABUSE HAS OCCURRED, THE MATTER SHALL BE REFERRED TO THE ATTORNEY GENERAL.

B. ANY PERSON MAKING A COMPLAINT OR FURNISHING A REPORT, INFORMATION OR RECORDS IN GOOD FAITH PURSUANT TO THIS SECTION IS IMMUNE FROM ANY CIVIL LIABILITY BY REASON OF THAT ACTION UNLESS THAT PERSON HAS BEEN CHARGED WITH OR IS SUSPECTED OF THE REPORTED FRAUD OR ABUSE.

C. ANY HEALTH CARE PROVIDER WHO FAILS TO REPORT PURSUANT TO THIS SECTION COMMITS AN ACT OF UNPROFESSIONAL CONDUCT AND IS SUBJECT TO DISCIPLINARY ACTION BY THE PROVIDER'S LICENSING BOARD OR DEPARTMENT.

36-2993. Prohibited acts; penalties

A. A PERSON SHALL NOT PRESENT OR CAUSE TO BE PRESENTED TO THIS STATE OR TO A CONTRACTOR:

1. A CLAIM FOR A MEDICAL SERVICE OR ANY OTHER ITEM THAT THE PERSON KNOWS OR HAS REASON TO KNOW WAS NOT PROVIDED AS CLAIMED.

2. A CLAIM FOR A MEDICAL SERVICE OR ANY OTHER ITEM THAT THE PERSON KNOWS OR HAS REASON TO KNOW IS FALSE OR FRAUDULENT.

3. A CLAIM FOR PAYMENT THAT THE PERSON KNOWS OR HAS REASON TO KNOW MAY NOT BE MADE BY THE ADMINISTRATION BECAUSE:

(a) THE PERSON WAS TERMINATED OR SUSPENDED FROM PARTICIPATION IN THE PROGRAM ON THE DATE FOR WHICH THE CLAIM IS BEING MADE.

(b) THE ITEM OR SERVICE CLAIMED IS SUBSTANTIALLY IN EXCESS OF THE NEEDS OF THE INDIVIDUAL OR OF A QUALITY THAT FAILS TO MEET PROFESSIONALLY RECOGNIZED STANDARDS OF HEALTH CARE.

(c) THE PERSON WAS NOT A MEMBER ON THE DATE FOR WHICH THE CLAIM IS BEING MADE.

4. A CLAIM FOR A SERVICE OR AN ITEM BY A PERSON WHO KNOWS OR HAS REASON TO KNOW THAT THE INDIVIDUAL WHO FURNISHED OR SUPERVISED THE FURNISHING OF THE SERVICE:

(a) WAS NOT LICENSED AS A PHYSICIAN OR ANOTHER HEALTH CARE PROFESSIONAL REQUIRING STATE LICENSURE.

(b) OBTAINED THE INDIVIDUAL'S LICENSE THROUGH A MISREPRESENTATION OF MATERIAL FACT.

(c) REPRESENTED TO THE MEMBER AT THE TIME THE SERVICE WAS FURNISHED THAT THE PHYSICIAN WAS CERTIFIED IN A MEDICAL SPECIALTY BY A MEDICAL SPECIALTY BOARD IF THE INDIVIDUAL WAS NOT CERTIFIED.

5. A REQUEST FOR PAYMENT THAT THE PERSON KNOWS OR HAS REASON TO KNOW IS IN VIOLATION OF AN AGREEMENT BETWEEN THE PERSON AND THIS STATE OR THE ADMINISTRATION.

B. A PERSON WHO VIOLATES THIS SECTION IS SUBJECT, IN ADDITION TO ANY OTHER PENALTIES THAT MAY BE PRESCRIBED BY LAW, TO A CIVIL PENALTY OF NOT MORE THAN TWO THOUSAND DOLLARS FOR EACH ITEM OR SERVICE CLAIMED AND IS SUBJECT TO AN ASSESSMENT OF NOT MORE THAN TWICE THE AMOUNT CLAIMED FOR EACH ITEM OR SERVICE.

C. THE DIRECTOR OR THE DIRECTOR'S DESIGNEE SHALL MAKE THE DETERMINATION TO ASSESS CIVIL PENALTIES AND IS RESPONSIBLE FOR THE COLLECTION OF PENALTY AND ASSESSMENT AMOUNTS. THE DIRECTOR SHALL ADOPT RULES THAT PRESCRIBE PROCEDURES FOR THE DETERMINATION AND COLLECTION OF CIVIL PENALTIES AND ASSESSMENTS. CIVIL PENALTIES AND ASSESSMENTS IMPOSED UNDER THIS SECTION MAY BE COMPROMISED BY THE DIRECTOR OR THE DESIGNEE IN ACCORDANCE WITH CRITERIA ESTABLISHED IN RULES. THE DIRECTOR OR THE DIRECTOR'S DESIGNEE MAY MAKE THIS DETERMINATION IN THE SAME PROCEEDING TO EXCLUDE THE PERSON FROM PARTICIPATION IN THE PROGRAM.

D. A PERSON ADVERSELY AFFECTED BY A DETERMINATION OF THE DIRECTOR OR THE DIRECTOR'S DESIGNEE UNDER THIS SECTION MAY APPEAL THAT DECISION IN

ACCORDANCE WITH PROVIDER GRIEVANCE PROVISIONS PRESCRIBED BY RULE. THE FINAL DECISION IS SUBJECT TO JUDICIAL REVIEW PURSUANT TO TITLE 12, CHAPTER 7, ARTICLE 6.

E. THE ADMINISTRATION SHALL DEPOSIT, PURSUANT TO SECTIONS 35-146 AND 35-147, MONIES COLLECTED PURSUANT TO THIS SECTION IN THE STATE GENERAL FUND. THE AMOUNT OF THE PENALTY OR ASSESSMENT MAY BE DEDUCTED FROM ANY AMOUNT THEN OR LATER OWING BY THE ADMINISTRATION OR THIS STATE TO THE PERSON AGAINST WHOM THE PENALTY OR ASSESSMENT HAS BEEN IMPOSED.

F. IF A CIVIL PENALTY OR ASSESSMENT IMPOSED PURSUANT TO THIS SECTION IS NOT PAID, THIS STATE OR THE ADMINISTRATION SHALL FILE AN ACTION TO COLLECT THE CIVIL PENALTY OR ASSESSMENT IN THE SUPERIOR COURT IN MARICOPA COUNTY. MATTERS THAT WERE RAISED OR COULD HAVE BEEN RAISED IN A HEARING BEFORE THE DIRECTOR OR IN AN APPEAL PURSUANT TO TITLE 12, CHAPTER 7, ARTICLE 6 MAY NOT BE RAISED AS A DEFENSE TO THE CIVIL ACTION. AN ACTION BROUGHT PURSUANT TO THIS SUBSECTION SHALL BE INITIATED WITHIN SIX YEARS AFTER THE DATE THE CLAIM WAS PRESENTED.

36-2994. Monthly financial report

A. THE DIRECTOR SHALL INCLUDE IN THE MONTHLY REPORT SUBMITTED TO THE PRESIDENT OF THE SENATE AND THE SPEAKER OF THE HOUSE OF REPRESENTATIVES PURSUANT TO SECTION 36-2920 THE FOLLOWING INFORMATION ABOUT THE PROGRAM:

1. THE ACTUAL YEAR TO DATE EXPENDITURES AND PROJECTED ANNUAL EXPENDITURES.

2. THE ACTUAL MEMBER MONTHS.

3. MONIES RECOVERED MONTHLY FROM THIRD PARTY PAYORS.

4. THE AMOUNT AND ORIGIN OF ANY DONATION OR GRANT FROM A PRIVATE ENTITY AND THE IMPACT ON THE IMPLEMENTATION OF THE PROGRAM.

B. THE REPORT SHALL BE SUBMITTED ON OR BEFORE THE TWENTY-FIFTH DAY OF THE FOLLOWING MONTH.

C. THE DIRECTOR SHALL PROVIDE A COPY OF THE MONTHLY REPORT TO THE CHAIRMEN OF THE HOUSE OF REPRESENTATIVES AND SENATE STANDING COMMITTEES ON APPROPRIATIONS AND HEALTH.

36-2995. Children's health insurance program fund; sources of monies; use; reversion; claims

A. THE CHILDREN'S HEALTH INSURANCE PROGRAM FUND IS ESTABLISHED. THE ADMINISTRATION SHALL ADMINISTER THE FUND AND SHALL USE FUND MONIES TO PAY ADMINISTRATIVE AND PROGRAM COSTS ASSOCIATED WITH THE OPERATION OF THE PROGRAM ESTABLISHED BY THIS ARTICLE.

B. SEPARATE ACCOUNTING SHALL BE MADE FOR EACH SOURCE OF MONIES RECEIVED PURSUANT TO SUBSECTION C OF THIS SECTION FOR EXPENSES AND INCOME ACTIVITY ASSOCIATED WITH THE PROGRAM ESTABLISHED PURSUANT TO THIS ARTICLE.

C. MONIES IN THE FUND ARE COMPRISED OF:

1. FEDERAL MONIES AVAILABLE TO THIS STATE FOR THE OPERATION OF THE PROGRAM.

2. TOBACCO TAX AND STATE GENERAL FUND MONIES APPROPRIATED AS STATE MATCHING MONIES.

3. GIFTS, DONATIONS AND GRANTS FROM ANY SOURCE.
4. INTEREST PAID ON MONIES DEPOSITED IN THE FUND.
5. THIRD PARTY LIABILITY RECOVERIES.

D. IF A GIFT, A DONATION OR A GRANT OF OVER TEN THOUSAND DOLLARS RECEIVED FROM ANY PRIVATE SOURCE CONTAINS A CONDITION, THE ADMINISTRATION SHALL FIRST MEET WITH THE JOINT LEGISLATIVE STUDY COMMITTEE ON THE INTEGRATION OF HEALTH CARE SERVICES TO REVIEW THE CONDITION BEFORE IT SPENDS THAT GIFT, DONATION OR GRANT.

E. ALL MONIES IN THE FUND OTHER THAN MONIES APPROPRIATED BY THIS STATE DO NOT LAPSE.

F. MONIES APPROPRIATED FROM THE MEDICALLY NEEDY ACCOUNT OF THE TOBACCO TAX AND HEALTH CARE FUND ARE EXEMPT FROM SECTION 35-190 RELATING TO LAPSING OF APPROPRIATIONS. NOTWITHSTANDING SECTION 35-191, SUBSECTION B, THE PERIOD FOR ADMINISTRATIVE ADJUSTMENTS EXTENDS FOR ONLY SIX MONTHS FOR APPROPRIATIONS MADE FOR ADMINISTRATION COVERED SERVICES.

G. NOTWITHSTANDING SECTIONS 35-190 AND 35-191, ALL APPROVED CLAIMS FOR SYSTEM COVERED SERVICES PRESENTED AFTER THE END OF THE FISCAL YEAR IN WHICH THEY WERE INCURRED SHALL BE PAID EITHER IN ACCORDANCE WITH THIS SECTION OR IN THE CURRENT FISCAL YEAR WITH THE MONIES AVAILABLE IN THE FUNDS ESTABLISHED BY THIS SECTION.

H. CLAIMS FOR COVERED SERVICES THAT ARE DETERMINED TO BE VALID BY THE DIRECTOR AND THE GRIEVANCE AND APPEAL PROCEDURE SHALL BE PAID FROM THE CHILDREN'S HEALTH INSURANCE PROGRAM FUND.

I. ALL PAYMENTS FOR CLAIMS FROM THE CHILDREN'S HEALTH INSURANCE PROGRAM FUND SHALL BE ACCOUNTED FOR BY THE ADMINISTRATION BY THE FISCAL YEAR IN WHICH THE CLAIMS WERE INCURRED, REGARDLESS OF THE FISCAL YEAR IN WHICH THE PAYMENTS WERE MADE.

J. NOTWITHSTANDING ANY OTHER LAW, COUNTY OWNED OR CONTRACTED PROVIDERS AND SPECIAL HEALTH CARE DISTRICT OWNED OR CONTRACTED PROVIDERS ARE SUBJECT TO ALL CLAIMS PROCESSING AND PAYMENT REQUIREMENTS OR LIMITATIONS OF THIS CHAPTER THAT ARE APPLICABLE TO NONCOUNTY PROVIDERS.

36-2998. Qualifying plans

A. A QUALIFYING PLAN, AS DEFINED IN SECTION 36-2981, MAY ELECT TO PARTICIPATE IN THE CHILDREN'S HEALTH INSURANCE PROGRAM ESTABLISHED PURSUANT TO THIS ARTICLE, SUBJECT TO ALL REQUIREMENTS ESTABLISHED IN THIS ARTICLE AND IN ACCORDANCE WITH SECTION 36-2989.

B. THE DIRECTOR OF THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM SHALL ESTABLISH THE TERMS AND CONDITIONS THAT SHALL BE USED TO EXERCISE THE OPTION TO PARTICIPATE.

Sec. 8. Section 36-3408, Arizona Revised Statutes, as amended by Laws 2010, seventh special session, chapter 10, section 11, is amended to read:

36-3408. Eligibility for behavioral health service system; screening process; required information

A. Any person or the person's parent or legal guardian who requests behavioral health services pursuant to this chapter shall comply with a

preliminary financial screening and eligibility process developed by the department of health services in coordination with the Arizona health care cost containment system administration and administered at the initial intake level. A person who receives behavioral health services pursuant to this chapter and who has not been determined eligible for title XVIII and for the medicare part D prescription drug benefit, ~~or~~ title XIX OR TITLE XXI services shall comply annually with the eligibility determination process. If the results indicate that the person may be eligible for title XVIII and for the medicare part D prescription drug benefit, ~~or~~ title XIX OR TITLE XXI, in order to continue to receive services pursuant to this chapter, the applicant shall submit a completed application within ten working days to the social security administration, the department of economic security or the Arizona health care cost containment system administration, which shall determine the applicant's eligibility pursuant to title XVIII and for the medicare part D prescription drug benefit, section 36-2901, paragraph 6, subdivision (a), ~~or~~ section 36-2931, paragraph 5 OR SECTION 36-2981, PARAGRAPH 6 for health and medical or long-term care services pursuant to chapter 29 of this title. The applicant shall cooperate fully with the eligibility determination process. If the person is in need of emergency services provided pursuant to this chapter, the person may begin to receive these services immediately provided that within five days from the date of service a financial screening is initiated.

B. Applicants who refuse to cooperate in the financial screening and eligibility process are not eligible for services pursuant to this chapter. A form explaining loss of benefits due to refusal to cooperate shall be signed by the applicant. Refusal to cooperate shall not be construed to mean the applicant's inability to obtain documentation required for eligibility determination. The department of economic security and the Arizona health care cost containment system administration shall promptly inform the department of health services of the applications that are denied based on an applicant's failure to cooperate with the eligibility determination process and, on request, of applicants who do not submit an application as required by this section.

C. The department of economic security, in coordination with the department of health services, shall provide on-site eligibility determinations at appropriate program locations subject to legislative appropriation.

D. This section only applies to persons who receive services that are provided pursuant to this section and that are paid for in whole or in part with state funds.

E. A person who requests treatment services under this chapter shall provide personally identifying information required by the department of health services.

F. Except as otherwise provided by law, this section and cooperation with the eligibility determination process do not entitle any person to any particular services that are subject to legislative appropriation.

Sec. 9. Section 38-651, Arizona Revised Statutes, is amended to read:

38-651. Expenditure of monies for health and accident insurance; definition

A. The department of administration may expend public monies appropriated for such purpose to procure health and accident coverage for full-time officers and employees of this state and its departments and agencies. The department of administration may adopt rules that provide that if an employee dies while the employee's surviving spouse's health insurance is in force, the surviving spouse is entitled to no more than thirty-six months of extended coverage at one hundred two per cent of the group rates by paying the premiums. No public monies may be expended to pay all or any part of the premium of health insurance continued in force by the surviving spouse. The department of administration shall seek a variety of plans, including indemnity health insurance, hospital and medical service plans, dental plans and health maintenance organizations. On a recommendation of the department of administration and the review of the joint legislative budget committee, the department of administration may self-insure for the purposes of this subsection. If the department of administration self-insures, the department may contract directly with preferred provider organizations, physician and hospital networks, indemnity health insurers, hospital and medical service plans, dental plans and health maintenance organizations. If the department self-insures, the department shall provide that the self-insurance program include all health coverage benefits that are mandated pursuant to title 20. The self-insurance program shall include provisions to provide for the protection of the officers and employees, including grievance procedures for claim or treatment denials, creditable coverage determinations, dissatisfaction with care and access to care issues. The department of administration by rule shall designate and adopt performance standards, including cost competitiveness, utilization review issues, network development and access, conversion and implementation, report timeliness, quality outcomes and customer satisfaction for qualifying plans. The qualifying plans for which the standards are adopted include indemnity health insurance, hospital and medical service plans, closed panel medical and dental plans and health maintenance organizations, and for eligibility of officers and employees to participate in such plans. Any indemnity health insurance or hospital and medical service plan designated as a qualifying plan by the department of administration must be open for enrollment to all permanent full-time state employees, except that any plan established prior to June 6, 1977 may be continued as a separate plan. Any closed panel medical or dental plan or health maintenance organization designated as the qualifying plan by the department of administration must be open for enrollment to all permanent full-time state employees residing within the

geographic area or area to be served by the plan or organization. Officers and employees may select coverage under the available options.

B. The department of administration may expend public monies appropriated for such purpose to procure health and accident coverage for the dependents of full-time officers and employees of this state and its departments and agencies. The department of administration shall seek a variety of plans, including indemnity health insurance, hospital and medical service plans, dental plans and health maintenance organizations. On a recommendation of the department of administration and the review of the joint legislative budget committee, the department of administration may self-insure for the purposes of this subsection. If the department of administration self-insures, the department may contract directly with preferred provider organizations, physician and hospital networks, indemnity health insurers, hospital and medical service plans, dental plans and health maintenance organizations. If the department self-insures, the department shall provide that the self-insurance program include all health coverage benefits that are mandated pursuant to title 20. The self-insurance program shall include provisions to provide for the protection of the officers and employees, including grievance procedures for claim or treatment denials, creditable coverage determinations, dissatisfaction with care and access to care issues. The department of administration by rule shall designate and adopt performance standards, including cost competitiveness, utilization review issues, network development and access, conversion and implementation, report timeliness, quality outcomes and customer satisfaction for qualifying plans. The qualifying plans for which the standards are adopted include indemnity health insurance, hospital and medical service plans, closed panel medical and dental plans and health maintenance organizations, and for eligibility of the dependents of officers and employees to participate in such plans. Any indemnity health insurance or hospital and medical service plan designated as a qualifying plan by the department of administration must be open for enrollment to all permanent full-time state employees, except that any plan established prior to June 6, 1977 may be continued as a separate plan. Any closed panel medical or dental plan or health maintenance organization designated as a qualifying plan by the department of administration must be open for enrollment to all permanent full-time state employees residing within the geographic area or area to be served by the plan or organization. Officers and employees may select coverage under the available options.

C. The department of administration may designate the Arizona health care cost containment system established by title 36, chapter 29 as a qualifying plan for the provision of health and accident coverage to full-time state officers and employees and their dependents. The Arizona health care cost containment system shall not be the exclusive qualifying plan for health and accident coverage for state officers and employees either on a statewide or regional basis.

D. Except as provided in section 38-652, public monies expended pursuant to this section each month shall not exceed:

1. Five hundred dollars multiplied by the number of officers and employees who receive individual coverage.

2. One thousand two hundred dollars multiplied by the number of married couples if both members of the couple are either officers or employees and each receives individual coverage or family coverage.

3. One thousand two hundred dollars multiplied by the number of officers or employees who receive family coverage if the spouses of the officers or employees are not officers or employees.

E. Subsection D of this section:

1. Establishes a total maximum expenditure of public monies pursuant to this section.

2. Does not establish a minimum or maximum expenditure for each individual officer or employee.

F. In order to ensure that an officer or employee does not suffer a financial penalty or receive a financial benefit based on the officer's or employee's age, gender or health status, the department of administration shall consider implementing the following:

1. Requests for proposals for health insurance that specify that the carrier's proposed premiums for each plan be based on the expected age, gender and health status of the entire pool of employees and officers and their family members enrolled in all qualifying plans and not on the age, gender or health status of the individuals expected to enroll in the particular plan for which the premium is proposed.

2. Recommendations from a legislatively established study group on risk adjustments relating to a system for reallocating premium revenues among the contracting qualifying plans to the extent necessary to adjust the revenues received by any carrier to reflect differences between the average age, gender and health status of the enrollees in that carrier's plan or plans and the average age, gender and health status of all enrollees in all qualifying plans.

G. Each officer or employee shall certify on the initial application for family coverage that the officer or employee is not receiving more than the contribution for which eligible pursuant to subsection D of this section. Each officer or employee shall also provide the certification on any change of coverage or marital status.

H. If a qualifying health maintenance organization is not available to an officer or employee within fifty miles of the officer's or employee's residence and the officer or employee is enrolled in a qualifying plan, the officer or employee shall be offered the opportunity to enroll with a health maintenance organization when the option becomes available. If a health maintenance organization is available within fifty miles and it is determined by the department of administration that there is an insufficient number of medical providers in the organization, the department may provide for a

change in enrollment from plans designated by the director when additional medical providers join the organization.

I. Notwithstanding subsection H of this section, officers and employees who enroll in a qualifying plan and reside outside the area of a qualifying health maintenance organization shall be offered the option to enroll with a qualified health maintenance organization offered through their provider under the same premiums as if they lived within the area boundaries of the qualified health maintenance organization, if:

1. All medical services are rendered and received at an office designated by the qualifying health maintenance organization or at a facility referred by the health maintenance organization.

2. All nonemergency or nonurgent travel, ambulatory and other expenses from the residence area of the officer or employee to the designated office of the qualifying health maintenance organization or the facility referred by the health maintenance organization are the responsibility of and at the expense of the officer or employee.

3. All emergency or urgent travel, ambulatory and other expenses from the residence area of the officer or employee to the designated office of the qualifying health maintenance organization or the facility referred by the health maintenance organization are paid pursuant to any agreement between the health maintenance organization and the officer or employee living outside the area of the qualifying health maintenance organization.

J. The department of administration shall allow any school district in this state that meets the requirements of section 15-388, a charter school in this state that meets the requirements of section 15-187.01 or a city, town, county, community college district, special taxing district, authority or public entity organized pursuant to the laws of this state that meets the requirements of section 38-656 to participate in the health and accident coverage prescribed in this section, except that participation is only allowed in a health plan that is offered by the department and that is subject to title 20, chapter 1, article 1. A school district, a charter school, a city, a town, a county, a community college district, a special taxing district, an authority or any public entity organized pursuant to the laws of this state rather than this state shall pay directly to the benefits provider the premium for its employees.

K. The department of administration shall determine the actual administrative and operational costs associated with school districts, charter schools, cities, towns, counties, community college districts, special taxing districts, authorities and public entities organized pursuant to the laws of this state participating in the state health and accident insurance coverage. These costs shall be allocated to each school district, charter school, city, town, county, community college district, special taxing district, authority and public entity organized pursuant to the laws of this state based on the total number of employees participating in the

coverage. This subsection only applies to a health plan that is offered by the department and that is subject to title 20, chapter 1, article 1.

L. Insurance providers contracting with this state shall separately maintain records that delineate claims and other expenses attributable to participation of a school district, charter school, city, town, county, community college district, special taxing district, authority and public entity organized pursuant to the laws of this state in the state health and accident insurance coverage and, by November 1 of each year, shall report to the department of administration the extent to which state costs are impacted by participation of school districts, charter schools, cities, towns, counties, community college districts, special taxing districts, authorities and public entities organized pursuant to the laws of this state in the state health and accident insurance coverage. By December 1 of each year, the director of the department of administration shall submit a report to the president of the senate and the speaker of the house of representatives detailing the information provided to the department by the insurance providers and including any recommendations for possible legislative action.

M. Notwithstanding subsection J of this section, any school district in this state that meets the requirements of section 15-388, a charter school in this state that meets the requirements of section 15-187.01 or a city, town, county, community college district, special taxing district, authority or public entity organized pursuant to the laws of this state that meets the requirements of section 38-656 may apply to the department of administration to participate in the self-insurance program that is provided by this section pursuant to rules adopted by the department. A participating entity shall reimburse the department for all premiums and administrative or other insurance costs. The department shall actuarially prescribe the annual premium for each participating entity to reflect the actual cost of each participating entity.

N. Any person that submits a bid to provide health and accident coverage pursuant to this section shall disclose any court or administrative judgments or orders issued against that person within the last ten years before the submittal.

O. For the purposes of this section, ~~beginning October 1, 2009,~~ "dependent" means a spouse under the laws of this state, a child who is under ~~nineteen years of age or a child who is under twenty-three~~ TWENTY-SIX years of age ~~and who is a full-time student~~ OR A CHILD WHO WAS DISABLED BEFORE REACHING NINETEEN YEARS OF AGE, WHO CONTINUES TO BE DISABLED UNDER 42 UNITED STATES CODE SECTION 1382c AND FOR WHOM THE EMPLOYEE HAD CUSTODY BEFORE REACHING NINETEEN YEARS OF AGE.

Sec. 10. Laws 2010, seventh special session, chapter 1, section 133 is amended to read:

Sec. 133. AHCCCS; appropriation reduction; medicare clawback; 2009-2010

A. In addition to any other appropriation reductions made in fiscal year 2009-2010, notwithstanding any other law, the appropriation to the Arizona health care cost containment system is reduced by $15,354,900 from the state general fund for medicare clawback payments.

B. In addition to any other appropriation reductions made in fiscal year 2009-2010, notwithstanding any other law, the appropriation to the Arizona health care cost containment system is reduced by $3,633,100 from ~~federal title XIX~~ expenditure authority for medicare clawback payments.

Sec. 11. Repeal

Laws 2010, seventh special session, chapter 10, section 10 is repealed.

Sec. 12. Appropriation; children's health insurance program

In addition to any other appropriation made in fiscal year 2010-2011, the sum of $9,000,000 from the state general fund and $40,900,000 from the children's health insurance program fund is appropriated in fiscal year 2010-2011 to the Arizona health care cost containment system administration for the purposes of providing services under the children's health insurance program.

Sec. 13. ALTCS; county contributions; fiscal year 2010-2011

A. If the federal government extends the enhanced federal match rate through June 30, 2011, notwithstanding Laws 2010, seventh special session, chapter 10, section 15 and section 11-292, Arizona Revised Statutes, county contributions for the Arizona long-term care system for fiscal year 2010-2011 are as follows:

1.	Apache	$ 469,400
2.	Cochise	$ 4,023,400
3.	Coconino	$ 1,408,800
4.	Gila	$ 1,623,600
5.	Graham	$ 1,072,900
6.	Greenlee	$ 122,200
7.	La Paz	$ 619,700
8.	Maricopa	$115,295,400
9.	Mohave	$ 5,479,700
10.	Navajo	$ 1,942,400
11.	Pima	$ 29,839,700
12.	Pinal	$ 11,132,800
13.	Santa Cruz	$ 1,434,600
14.	Yavapai	$ 7,024,400
15.	Yuma	$ 6,018,000

B. The amounts specified in subsection A of this section reflect $76,014,400 in decreases in county contributions for the Arizona long-term care system.

C. The amounts specified in subsection A of this section reflect $4,390,700 in decreases in county contributions for the Arizona long-term care system for medicare clawback savings.

D. The county contributions for the Arizona long-term care system would have otherwise totaled $267,912,100 in fiscal year 2010-2011.

Sec. 14. Supplemental appropriation; reduction; enhanced federal matching rate; fiscal year 2010-2011

A. If the federal government extends the enhanced federal match rate through June 30, 2011, in addition to any other appropriations and appropriation reductions made in fiscal year 2010-2011, the following appropriations and reductions are made in fiscal year 2010-2011 to the following agencies:

1. The sum of $43,000,000 is reduced from the state general fund appropriation made and $43,000,000 is appropriated in additional expenditure authority of federal monies to the department of economic security.

2. The sum of $45,000,000 is reduced from the state general fund appropriation made and $86,000,000 is appropriated in additional expenditure authority to the department of health services.

3. The sum of $79,000,000 is appropriated from the state general fund and $1,006,000,000 is appropriated in additional expenditure authority to the Arizona health care cost containment system administration.

B. If the condition specified in subsection A is met, it is the intent of the legislature that the Arizona health care cost containment system administration spend an additional $361,000,000 in state general fund monies in fiscal year 2010-2011 on proposition 204 costs and that the department of health services spend an additional $24,000,000 in state general fund monies in fiscal year 2010-2011 on proposition 204 costs.

Sec. 15. Department of administration; dependent coverage; state employee health benefits

The department of administration may adopt rules consistent with any federal rules promulgated pursuant to the patient protection and affordable care act of 2010 (P.L. 111-148) relating to dependent coverage to further define dependent as defined in section 38-651, Arizona Revised Statutes, as amended by this act, consistent with the federal law.

Sec. 16. Retroactivity

Sections 1, 2, 3, 4, 5, 6, 7, 8, 11 and 12 of this act are effective retroactively to from and after June 14, 2010.

APPROVED BY THE GOVERNOR MAY 6, 2010.

FILED IN THE OFFICE OF THE SECRETARY OF STATE MAY 6, 2010.